# EXHIBIT L

Page  SUPERIOR COURT OF NEW JERSEY LAW DIVISION  ATLANTIC COUNTY CASE NO. 291 CT  MASTER CASE NO. L-6341-10  IN RE: PELVIC MESH/GYNECARE LITIGATION  VOLUME I Thursday, November 15, 2012  Oral deposition of DANIEL STEVEN ELLIOTT, M.D., held at MAZIE SLATER KATZ & FREEMAN, L.L.C., 103 Eisenhower Farkway, Roseland, New Jersey, commencing at approximately 9:56 a.m., before Rosemary Locklear, a Registered Professional Reporter, Certified Realtime Reporter, Certified Court Reporter (NJ License No. 30XI00171000), and Notary Public.  GOLKOW TECHNOLOGIES, INC. 877.370.3377 ph   971.591.5672 Fax	1 APPEARANCES: 2 3 ANDERSON LAW OFFICES, L.L.C. BY: BENJAMIN H. ANDERSON, ESQUIRE 4 ben@andersonlawoffices.net 1360 West 9th Street, Suite 215 5 Cleveland, Ohio 44113 (216) 589-0256 6 and THE RESTAINO LAW FIRM, P.C. 7 BY: JOHN M. RESTAINO, JR., ESQUIRE jrestaino@restainolawfirm.com 8 1550 Larimer Street, Suite 527 Denver, Colorado 80202 9 (720) 924-2006 Appearing on behalf of the Plaintiffs 10 11 BUTLER SNOW O'MARA STEVENS & CANNADA, P.L.L.C. 12 BY: NILS B. (BURT) SNELL, ESQUIRE burt.snell@butlersnow.com 13 500 Office Center Drive, Suite 400 Fort Washington, Pennsylvania 19034 (267) 513-1885 Appearing on behalf of the Defendants Johnson 15 & Johnson and Ethicon 16 17 SILLS CUMMIS EPSTEIN & GROSS, P.C. BY: WILLIAM R. STUART, III., ESQUIRE wstuart@sillscummmis.com The Legal Center, One Riverfront Plaza Newark, New Jersey 07102 (973) 643-7000 20 Appearing on behalf of the Defendant Caldero Medical, Inc.	Page 2
Page  I N D E X  NITNESS PAGE  A DANIEL STEVEN ELLIOTT, M.D.  By Mr. Snell 8  Elliott MAR  Elliott MAR  Elliott MAR  Elliott (General)"  1 1 0-page copy of document dated 8  10/12/12 entitled "Notice to Take Deposition of Dr. Daniel Elliott (General)"  2 4-page copy of letter dated 11/7/12 64  to Benjamin H. Anderson, Esq., from Daniel S. Elliott, M.D.  3 4-page copy of article dated 6/12/03 156  entitled "Robotic-Assisted Laparoscopic Sacrocolpopexy for Treatment of Vaginal Vault Prolapse"  4 5-page copy of article dated 2004 165  entitled "Gynecologic use of robotically assisted laparoscopy: sacrocolpopexy for the treatment of high-grade vaginal vault prolapse"  5 5-page copy of article dated 9/13/05 172  entitled "Long-Term Results of Robotic Assisted Laparoscopic Sacrocolpopexy for the Treatment of High Grade Vaginal Vault Prolapse"  A Robotic Assisted Laparoscopic Sacrocolpopexy for the treatment of high-grade vaginal vault prolapse"  A Robotic Assisted Laparoscopic Sacrocolpopexy for the Treatment of High Grade Vaginal Vault Prolapse"	25	Page 4

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1	DEPOSITION SUPPORT INDEX	1	Reserved for Confidential Designation Index as
2		2	Pursuant to the Protective Order
3	Directions to Witness Not to Answer	3	
4	Page Line	4	Defendants did not have any Confidential Designations.
5	, and the second	5	,
6		6	
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8	Request for Production of Documents	8	
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20	Question Marked	20	
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	Dage 7		Dage 0
1	Page 7 Reserved for Confidential Designation Index as	1	Page 8
1 2	Pursuant to the Protective Order	1 2	(Exhibit Elliott-1 was marked for identification.)
3	ruisuant to the Protective Order	3	DANIEL STEVEN ELLIOTT, M.D.,
4		4	having been duly sworn, was examined and
5		5	testified as follows:
6		6	EXAMINATION
7		7	BY MR. SNELL:
1 ~		_	
9		8	
10		10	A. Good morning. Q. My name is Burt Snell, and I'm
11		11	here to take your deposition in the
12		12	litigation involving Ethicon surgical meshes
13		13	for prolapse and urinary incontinence.
14		14	Have you ever given a
15		15	deposition before?
16		16	A. Yes.
17		17	Q. On how many occasions?
18		18	A. A rough estimate would be about
19		19	15.
20		20	Q. So I'll give you a quick,
121		21	abbreviated instructions list. You know all
21		21	abbreviated instructions list. You know all these things
22		22	these things.
22 23		22 23	these things. You're here under oath, just
22		22	these things.

1				
1	Pa	age 9		Page 10
	Q. You need to answer all my		1	Do you have any questions
2	questions verbally. Shaking or nodding of		2	before we begin?
3	the head does not translate into the record.		3	A. No.
4	Try to avoid saying unh-unh or uh-huh		4	Q. When was the first time you gave
5	because those do get jumbled.		5	a deposition?
6	If you can wait for my question		6	A. I won't be able to tell you an
7	to end before you answer and I'll do my best		7	exact date. It probably would have been
8			8	
	not to speak over you before you're finished			because I've been on staff at Mayo since
9	answering, that way we get a clean record.		9	2000. It would have been a year or two
10	Sometimes you'll probably know where I'm		10	after that, probably. That's a very rough
11	going and you'll be ready to answer but just		11	estimate.
12	let me finish my question so we can get a		12	Q. Your best approximation is
13	clear transcript.		13	somewhere around 2002?
14	Is that okay?		14	A. That's a fair estimate.
15	A. Sure.		15	Q. Have you ever given testimony at
16	Q. If you don't understand one of my		16	trial?
17	questions, please feel free to tell me, ask		17	A. Yes.
18	me to rephrase it or repeat it. I don't		18	Q. On how many occasions?
19	profess to be a physician, I'm not a doctor,		19	A. Once.
20	so sometimes I might mix up terminology.		20	Q. Where was that trial at?
21	It's okay to correct me or tell me, you		21	A. Tacoma, Washington. The district
22	know, that you'd like me to rephrase it or		22	courthouse there, I believe.
23	if you can answer it as best you can if you		23	Q. What type of case was it?
24	think you understand it, just feel free to		24	A. Patent infringement.
25	do so.		25	Q. Besides today, when was the last
	Pac	ge 11		Page 12
1	time you gave a deposition?	90	4	
	ante you gave a acposition.			O So these denositions involved
ı /	Δ I believe June maybe May of		1	Q. So these depositions involved
2	A. I believe June, maybe May, of		2	your role as a treating physician for the
3	this year, 2012.		2	your role as a treating physician for the patient?
3 4	this year, 2012. Q. Have you ever testified in a case		2 3 4	your role as a treating physician for the patient?  A. Correct. Yes. I was not the one
3 4 5	this year, 2012. Q. Have you ever testified in a case as an expert witness?		2 3 4 5	your role as a treating physician for the patient?  A. Correct. Yes. I was not the one being sued.
3 4 5 6	this year, 2012. Q. Have you ever testified in a case as an expert witness? A. Yes.		2 3 4 5 6	your role as a treating physician for the patient?  A. Correct. Yes. I was not the one being sued.  Q. Have you ever been sued?
3 4 5 6 7	this year, 2012. Q. Have you ever testified in a case as an expert witness? A. Yes. Q. On how many occasions?		2 3 4 5 6 7	your role as a treating physician for the patient?  A. Correct. Yes. I was not the one being sued.  Q. Have you ever been sued?  A. No.
3 4 5 6 7 8	this year, 2012. Q. Have you ever testified in a case as an expert witness? A. Yes. Q. On how many occasions? A. Once.		2 3 4 5 6 7 8	your role as a treating physician for the patient?  A. Correct. Yes. I was not the one being sued.  Q. Have you ever been sued?  A. No.  Q. And all of these patients were
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Page 13 Page 14 remember them. I can't recall them. Even 1 I'm only going to give you a rough estimate. 1 2 The first six, seven depositions were all 2 the one in June I can't recall. I remember 3 3 involving non-medical devices, surgical some issues pertaining to the case but not 4 issues, and then the last seven or so --4 the patient name. 5 again, that's a rough estimate -- were all 5 Q. Can you tell me the issues you 6 pertaining to meshes for transvaginal use. 6 recall pertaining to the case? 7 Can you tell me the names of the 7 Most specifically, the one in May 8 patients or the case names of these meshes 8 or June was a transvaginal mesh for prolapse. I don't recall which company 9 -- sorry -- of the cases that involved 9 10 transvaginal mesh? 10 product it was. The woman had it placed in Atlanta, I do know that, and she had 11 A. I don't understand your question. 11 You changed it. What are you asking? 12 12 complications. O. Can you tell me the names of the What type of complications? 13 13 O. patients, the plaintiffs, in these cases Pelvic pain, dyspareunia, voiding 14 14 where you've testified as a treater where dysfunction, ambulatory difficulties. Off 15 15 the top of my head, that's fairly thorough. the case involved transvaginal mesh use? 16 16 O. Do you recall the name of the Well, for confidentiality 17 17 18 purposes, I can't be giving you patient 18 physician involved or any of the physicians? names. Number one, I won't be able to Excuse me. No, I do not. 19 19 20 remember them. But if I could remember 20 Q. Do you recall the name of the 21 them, I can't give you their names. 21 lawyers who took your deposition? A. They were based in Atlanta so I 22 Q. You can give the names. If you 22 don't -- I'm not familiar. 23 were testifying in a litigation, in a 23 24 deposition, that's public. 24 Did anyone represent you at that Q. A. Okay. Then I -- well, I can't 25 25 deposition? Page 15 Page 16 Well, no one -- I mean, Mayo has 1 No, I do not. 1 A. 2 their team of 30 or 40 lawyers. So no one Do you have a recollection, then, 2 3 was in the room with me representing me. I 3 as to whether any of these were Prolifts® 4 had access to the Mayo legal team if I asked 4 which you gave testimony on as a treating 5 for it, but I didn't ask for it. So I don't 5 doctor? 6 know if that answers your question or not. 6 A. I don't recall. All I can 7 7 remember, again, just the most recent one O. No. That does. 8 8 Can you tell me the details of was in May or June and that was not. That 9 any of the other cases in which you gave 9 was Avaulta, I believe. 10 testimony as a treating physician that 10 Q. Avaulta. involved mesh use or mesh used Again, just to emphasize, that is 11 11 a guess. I believe that's what it was. 12 transvaginally? 12 Q. As you sit here today, your best 13 A. I won't be able to give you 13 14 specifics just because I don't recall. recollection is it was Avaulta? 14 15 There are various different 15 A. Correct. with anti-incontinence procedures, bladder Q. Were any of the mesh products for 16 16 17 perforations, urethral perforations, pain. which you gave testimony as a treater that 17 18 And then with the meshes for transvaginal 18 involved transvaginal placement, did they purposes it would be, again, somewhat involve the Prosima® product? 19 19 20 similar, though usually it was pain, pelvic 20 A. I don't recall. pain or dyspareunia. But I must emphasize, 21 21 Did any of these cases involving 22 that's a rough estimate because I just don't 22 the transvaginal mesh for which you gave 23 testimony as a treating physician involve recall. 23 24 Q. You don't have a good 24 the Prolift® M? 25 25 A. I don't recall. recollection.

,	Page 17		Page 18
1	Q. Plus M?	1	Q. And where was that case situated
2	A. I don't recall.	2	at? Do you recall?
3	Q. Have you ever given testimony as	3	MR. ANDERSON: The TVT®?
4	a treating physician in a case that involved	4	MR. SNELL: Yes.
5	TVT®?	5	THE WITNESS: Where the TVT®
6	A. Yes.	6	was placed?
7	Q. On how many occasions?	7	BY MR. SNELL:
8	A. Again, I'm going to have to only	8	Q. Where was the TVT® case situated,
9	give you a rough estimate. It was probably	9	filed? Was it a Minnesota case or somewhere
10	one or two times. There's definitely once	10	else?
11	but, again, beyond that, I can't really	11	A. Oh. I have no idea. Because
12	accurately recall.	12	Mayo gets people from all over the world, so
13	Q. When was the first TVT® case that	13	all 50 states, so I don't I don't recall.
14		13 14	
	you gave testimony in?		Again, the only reason I
15	A. I don't recall. It would have	15	remember the one in the last one, the
16	been probably in the three or four or five	16	mesh case in June, was because it was a
17	years ago time range.	17	recent one and I had just been in Atlanta
18	Q. Were you also testifying in that	18	for another meeting so it's kind of stuck in
19	case as a treating physician?	19	my mind.
20	A. Yeah. I I was not the one who	20	Q. The TVT® case that you gave
21	put the product in. I was the one who took	21	testimony in, the first one, did it involve
22	care of the problem afterwards. So yes, it	22	the retropubic or transobturator product?
23	was the my care it was specifically my	23	A. No. It was the yeah, the
24	care from the first day she showed up in the	24	retropubic approach.
25	office until the last day I saw her.	25	Q. Do you recall the name of the
	Page 19		Page 20
1	plaintiff's counsel or the defense lawyer	1	Radiation can be given either
2	there?	2	external beam or with seed implants for
3	A. No, I do not.	3	prostate cancer. Seed implants, another
4	Q. Were you represented in that	4	term for that is brachytherapy. And then
5	matter, in that case?	5	the hole developed following that.
6	A. Same answer as before. To the	6	Q. And this was brachytherapy given
7	best of my knowledge, only one time I've had	7	by some other physician and not you?
8	the Mayo lawyer team in the room with me,	8	A. Correct. I did not give it.
9	and that was not pertaining to a mesh. So	9	Yeah.
10	Mayo legal team represents me but, again,	10	Q. What do you recall about the TVT®
11	they were not in the room.	11	retropubic case in which you gave testimony
12	Q. Can you tell me the case where	12	in as a treating physician?
13	you had the Mayo Clinic legal in the room	13	A. The one that I can remember in
14	with you?	14	particular, it was a bladder perforation.
15	A. It was my first or second	15	Q. Was the bladder perforation
16	deposition and it was a rectourethral	16	recognized at the time of surgery?
17	fistula following for prostate cancer,	17	A. No, it was not. Specifically, I
18	brachytherapy seeds, and a hole developed	18	can tell you there was a cystoscopy note
19	between the rectum and the prostate.	19	said there was no perforation.
20	Q. And how did it develop?	20	Q. What did your course of care
21	A. As a result of radiation therapy	21	consist of in that matter in which you gave
	· ,		, -
22	for brachytherapy.	22	deposition testimony upon?
		22 23	· · · · · · · · · · · · · · · · · · ·
22			A. Briefly, the patient came to see
22 23	Q. And this was radio radiation	23	· · · · · · · · · · · · · · · · · · ·

Page 21 Page 22 1 urination and pelvic pain. 1 question and answer his question. 2 We performed a physical exam, 2 THE WITNESS: Okay. 3 which, as I recall, was negative, performed 3 BY MR. SNELL: 4 a cystoscopic exam, which showed two meshes 4 O. Now, you said that there was --5 5 going through bilaterally in the bladder or you testified in TVT® cases one or two times 6 one on each side of the bladder. 6 and we talked about the TVT® retropubic 7 Q. Do you know who placed that mesh? 7 case. 8 8 A. It was an outside physician. I Can you tell me, what was the 9 don't recall who it was. 9 sum of your testimony in that TVT® 10 Q. In any of the 15 cases where you 10 retropubic case beyond, you know, the patient came to you as you testified --11 gave deposition testimony in as a treating 11 physician did you opine that another 12 12 Uh-huh. physician breached the standard of care in 13 13 -- you know, you did a workup and 14 any manner? 14 you found mesh? Again, it's going to be difficult What else, if anything, did you 15 15 to recall each one in particular. testify to in that matter? 16 16 From my recollection, no, They asked how did I treat the 17 17 18 because specifically I was to offer an 18 situation, which that was at that point in opinion specifically from the day they time an open surgical repair. We went 19 19 20 showed up at my office to the day they left. 20 through the abdomen and took out the mesh. 21 So I was instructed by the legal team not to 21 They wanted to know what was 22 offer an opinion --22 the end result of it, if it cured the problem that she presented with, which, as I 23 Q. I don't want you to tell me what 23 24 your legal team instructed you. 24 recall, the answer was yes. MR. ANDERSON: Listen to the 25 25 And then, again, as far as I Page 23 Page 24 recall, the discussion ended at that point 1 we were discussing, where did you physically 1 2 2 in time. I'm sure there were other sit when you gave that deposition testimony? 3 questions. I don't recall them, though. 3 A. At the Mayo Clinic in the legal Q. Who removed the mesh in that 4 4 office. 5 case? 5 Q. In the second TVT® retropubic 6 A. I did. And my surgical team. It 6 case where did you physically give 7 7 deposition testimony from? wasn't just me. 8 8 A. Same place. All my depositions Q. Did you remove the entire mesh or 9 just the portion that was in the bladder? 9 except for the patent infringement have been 10 A. We removed -- that's an excellent 10 in the legal office at Mayo. question because that pertains to overall And do you remember the names of 11 11 the attorneys in the second TVT® retropubic 12 12 care and recurrence. 13 We removed from the --13 case? 14 everything we get from beneath the skin 14 Α. No, I do not. 15 through the rectus, through the fascia, into 15 Do you remember approximately the bladder, and then deep down into the when you gave that deposition? 16 16 pelvis to the level of the endopelvic A. Again, it would have been -- no. 17 17 18 fascia. As I recall, we did not perforate 18 To answer your question, no, I can't. I the endopelvic fascia and remove the mean, I can give you a five-year time frame. 19 19 20 suburethral portion. 20 Q. The first TVT® retropubic case that we've discussed, was that the first one 21 The other TVT® case that you gave 21 testimony in as a treater, what type of TVT® 22 22 chronologically that you gave testimony in? product was that? That's the first one that I can 23 23 A. 24 A. It was a retropubic also. 24 remember. 25 And for the first TVT® case that 25 Q. That's fine.

	Pa	age 25			Page 26
1	And then now this second one we		1	which is the most recent one; correct?	-
2	were talking about is sometime after that?		2	A. Can you go back? Your question,	
3	A. I don't I don't recall the		3	then, so I make sure I understand, as I can	
4	dates.		4	recall	
5	Q. Okay.		5	Q. How about this? Let me withdraw	
6	A. I just happen to remember the		6	it.	
7	bladder perforation most notably.		7	Of the seven cases that you	
8	Q. Now, the second TVT® retropubic		8	gave deposition testimony in involving the	
9	case, can you tell me the sum and substance		9	transvaginal use of mesh, tell me the	
10	of your testimony in that case?		10	products that were involved.	
11	A. I don't I on that one I do		11	A. Okay. I the only ones I'll be	
12				· · · · · · · · · · · · · · · · · · ·	
	not remember any specifics.		12	able to specifically tell you would be TVT®	
13	Q. Earlier you testified that the		13	and then Avaulta. I do not recall all the	
14	last seven or so cases you gave deposition		14	others.	
15	testimony in involving transvaginal mesh		15	Q. As you sit here today, we've	
16	strike that.		16	discussed two TVT® cases; correct?	
17	You testified there were seven		17	A. Correct.	
18	or so depositions you gave pertaining to		18	Q. Are those the only two that you	
19	transvaginal mesh use; correct?		19	recall?	
20	A. Correct.		20	A. That I recall, yes.	
21	Q. And of those seven or so, two of		21	Q. And as you sit here today, we've	
22	them were TVT®.		22	discussed one case that was this year, I	
23	A. That's a rough estimate. Yes.		23	believe you testified in May or June.	
24	Q. That's fine.		24	A. Correct.	
25	One may have been Avaulta,		25	Q. And that you believe involved	
	D				Daga 20
1	Avaulta.	age 27	1	transcripts?	Page 28
2	A. Correct.		2	A. I would assume they would.	
3	Q. Are there any other Avaulta cases		3	Q. Have you ever testified in	
4	that you recall?		4	Federal Court?	
5	A. Not that I can recall, no.		5	A. I don't know what that the	
6	Q. For any of the other seven cases		6	case in Tacoma, that was a district court.	
7	that involved the use of transvaginal mesh		7	I don't know the hierarchy of courts.	
8	do you recall the names of any of those		8	Q. Tell me about the case in Tacoma.	
U			()		
9	patients?		9	What was your role giving	
9 10	patients? A. No.		9 10	What was your role giving testimony there?	
9 10 11	patients? A. No. Q. Do you recall the names of any of		9 10 11	What was your role giving testimony there?  A. It was a patent infringement	
9 10 11 12	patients? A. No. Q. Do you recall the names of any of the lawyers?		9 10 11 12	What was your role giving testimony there? A. It was a patent infringement case, Coloplast versus GMD, which was	
9 10 11 12 13	patients? A. No. Q. Do you recall the names of any of the lawyers? A. No. I could only give you the		9 10 11 12 13	What was your role giving testimony there?  A. It was a patent infringement case, Coloplast versus GMD, which was Generic Medical Devices. And my role was	
9 10 11 12 13 14	patients? A. No. Q. Do you recall the names of any of the lawyers? A. No. I could only give you the location that the last one was. They were		9 10 11 12 13 14	What was your role giving testimony there? A. It was a patent infringement case, Coloplast versus GMD, which was Generic Medical Devices. And my role was with Coloplast as far as my opinion, whether	
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Page 29 Page 30 the transobturator use of synthetic mesh? 1 Q. And what was your expert opinion 1 2 in that Coloplast matter with regard to the 2 A. It would have been specifically 3 transobturator approach? 3 the transobturator surgical approach. There 4 A. That the use of the GMD 4 was -- the mesh itself was not a part of --5 5 transobturator trochars and mesh infringed as far as I recall, not a part of the 6 upon the Coloplast-held patent. 6 patent. It was the surgical approach, the 7 Q. And when did you give this 7 transobturator, that Coloplast owned. So it 8 deposition testimony in the patent 8 was not inclusive or exclusive of a mesh infringement case for Coloplast? 9 9 being used. The deposition was given in 10 10 Q. And besides the synthetic mesh, 11 November of 2011. 11 can you tell me what other mesh material, cadaveric, autologous or whatever, is placed 12 Q. When were you retained as an 12 expert? through a transobturator approach? 13 13 And I assume this is for -- let 14 A. The summer of 2009. 14 Q. And I believe you earlier me back up. This -- I assume this is for 15 15 testified that you also testified at trial stress urinary incontinence, this patent 16 16 in that case as well. infringement? 17 17 18 A. Correct. 18 A. Correct. 19 Q. Was that a jury trial or a judge? 19 So for stress urinary 20 20 incontinence can you tell me what other Α. 21 Q. Did you issue any opinions about 21 material besides the synthetic mesh is placed via the transobturator approach? 22 -- strike that. 22 A. As far as I know, only synthetic 23 In this patent infringement 23 24 case that you gave deposition testimony in 24 meshes are. But that was not what the for Coloplast am I correct that it involved 25 25 patent was involving. Page 31 Page 32 And you've used synthetic meshes 1 whether the transobturator surgery was a 1 2 in placing -- strike that. 2 safe procedure? 3 3 You've used synthetic meshes in Yes. Α. 4 the past to treat stress urinary 4 Q. What did you testify in that 5 incontinence via the transobturator route; 5 regard? 6 6 correct? A. I felt when it was done 7 7 Correct. correctly, it was a safe procedure. Α. 8 8 Q. Did you give testimony about the Did you give any opinions in this Q. 9 patent infringement case about the condition 9 efficacy of the transobturator surgery to 10 of stress urinary incontinence and whether 10 treat stress urinary incontinence versus 11 it needed to be treated? other surgical options? 11 A. I gave as far as my expert report A. I don't recall that question ever 12 12 a description of stress urinary coming up or me offering an opinion. 13 13 incontinence. But, again, the patent was Q. You didn't put that in your 14 14 15 not pertaining to what is being treated. 15 report? The patent was the transobturator approach A. I don't recall that specifically, 16 16 using those products. 17 17 no. 18 Q. And the transobturator approach 18 Q. You mentioned you issued a report in that patent infringement case. to treat stress urinary incontinence; 19 19 20 20 Did you issue your report correct? before your deposition testimony? 21 Again, specifically, the patent 21 A. was the transobturator surgery. That's what 22 22 Yes. was being discussed. And if the GMD product How many times were you deposed 23 23 was infringing upon that patent. in that patent infringement case? 24 24 25 Q. Did you give any opinions about 25 A. Once.

		Page 33			Page 34
1	Q. And you gave trial testimony on		1	Q. Do you have a document, a list of	
2	one occasion.		2	testimony, that you have given in the past?	
3	A. Correct. Over two days, but		3	A. I still don't understand it. A	
4	yeah, one trial.		4	list of testimony? I don't	
5	Q. Did the General Medical Devices,		5	Q. Do you have a document which	
6	the party, have an expert opposite you?		6	contains a list of the prior depositions,	
7	A. Yes.		7	trial testimonies	
8	Q. What was his or her name?		8	A. Oh.	
9	A. Dr. George Webster.		9	Q you've given in the past?	
10	Q. Before being involved in that		10	A. No, I do not.	
11	case, did you know Dr. George Webster?		11	Q. You did not serve such a document	
12	A. Yes.		12	with your expert report in the patent	
13	Q. How did you know Dr. Webster?		13	infringement case?	
14	A. Through meetings.		14	A. No. So I just want to clarify,	
15	Q. What type of physician is		15	you're asking do I have a list of all the	
16	Dr. Webster?		16	depositions I've given? I mean, okay, no, I	
17	A. Urologist.		17	do not have that at all.	
18	Q. Where does he practice?		18	Q. A list of all the depositions	
19	A. Duke.		19	you've given in any matter.	
20			20	A. Yeah.	
	<del>-</del>				
21	patent infringement case?		21	Q. Not just involving Mayo.	
22	A. No, I'm not.		22	A. No. I have not given any	
23	Q. Do you have a list of testimony		23	depositions except being at Mayo. So during	
24	that you've given?		24	my training well, my training is Mayo. I	
25	A. I don't understand the question.		25	did one year of fellowship at Baylor College	
		Dago 2E			Dago 26
1	of Medicine at Houston I did not give	Page 35	1	should have been performed?	Page 36
1	of Medicine at Houston. I did not give	Page 35	1	should have been performed?	Page 36
2	anything there.	Page 35	2	A. No. You I again, let me go	Page 36
2 3	anything there. Q. In any of the cases where you	Page 35	2	A. No. You I again, let me go back to clarify.	Page 36
2 3 4	anything there. Q. In any of the cases where you testified with regard to the use of	Page 35	2 3 4	A. No. You I again, let me go back to clarify. Q. Uh-huh.	Page 36
2 3 4 5	anything there. Q. In any of the cases where you testified with regard to the use of transvaginal mesh did you testify that the	Page 35	2 3 4 5	<ul> <li>A. No. You I again, let me go</li> <li>back to clarify.</li> <li>Q. Uh-huh.</li> <li>A. Are you asking should a non-mesh</li> </ul>	Page 36
2 3 4 5 6	anything there. Q. In any of the cases where you testified with regard to the use of transvaginal mesh did you testify that the use of mesh was improper in that case?	Page 35	2 3 4 5 6	<ul> <li>A. No. You I again, let me go back to clarify.</li> <li>Q. Uh-huh.</li> <li>A. Are you asking should a non-mesh procedure have been performed?</li> </ul>	Page 36
2 3 4 5 6 7	anything there. Q. In any of the cases where you testified with regard to the use of transvaginal mesh did you testify that the use of mesh was improper in that case?  MR. ANDERSON: Objection.	Page 35	2 3 4 5 6 7	<ul> <li>A. No. You I again, let me go back to clarify.</li> <li>Q. Uh-huh.</li> <li>A. Are you asking should a non-mesh procedure have been performed?</li> <li>Q. Any other type of procedure.</li> </ul>	Page 36
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2 3 4 5 6 7 8 9	anything there. Q. In any of the cases where you testified with regard to the use of transvaginal mesh did you testify that the use of mesh was improper in that case? MR. ANDERSON: Objection. Go ahead. THE WITNESS: I'd have to	Page 35	2 3 4 5 6 7 8 9	<ul> <li>A. No. You I again, let me go back to clarify.</li> <li>Q. Uh-huh.</li> <li>A. Are you asking should a non-mesh procedure have been performed?</li> <li>Q. Any other type of procedure.</li> <li>A. Okay. No, I did not.</li> <li>Q. For example, just to make sure</li> </ul>	Page 36
2 3 4 5 6 7 8 9	anything there. Q. In any of the cases where you testified with regard to the use of transvaginal mesh did you testify that the use of mesh was improper in that case? MR. ANDERSON: Objection. Go ahead. THE WITNESS: I'd have to clarify the question. Please rephrase it so	Page 35	2 3 4 5 6 7 8 9	A. No. You I again, let me go back to clarify. Q. Uh-huh. A. Are you asking should a non-mesh procedure have been performed? Q. Any other type of procedure. A. Okay. No, I did not. Q. For example, just to make sure we're on the same page, if it was a case	Page 36
2 3 4 5 6 7 8 9 10 11	anything there. Q. In any of the cases where you testified with regard to the use of transvaginal mesh did you testify that the use of mesh was improper in that case? MR. ANDERSON: Objection. Go ahead. THE WITNESS: I'd have to clarify the question. Please rephrase it so I can understand.	Page 35	2 3 4 5 6 7 8 9 10 11	A. No. You I again, let me go back to clarify. Q. Uh-huh. A. Are you asking should a non-mesh procedure have been performed? Q. Any other type of procedure. A. Okay. No, I did not. Q. For example, just to make sure we're on the same page, if it was a case involving the Avaulta product, that's a	Page 36
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Page 37 Page 38 1 seven cases involving transvaginal use of 1 case where you've issued an expert report, 2 mesh did you give testimony that some other 2 have you issued an expert report in any 3 surgical procedure should have been 3 other case, setting aside the present case 4 performed instead of the particular 4 that we're here for today? 5 5 procedure in a case? No. That's the only one. 6 A. Okay. To the best of my 6 Was Coloplast the plaintiff or 7 knowledge, no, never. 7 defendant in that patent infringement case? 8 8 A. I'm not that great on legal O. The first six or seven terms, but they were -- Coloplast was suing 9 depositions you gave involved surgical 9 GMD for infringement so I assume that's 10 issues. 10 11 A. Correct. 11 plaintiff. 12 Q. Can you tell me what they 12 Q. Do you have transcripts of your deposition or trial testimony from the 13 involved? 13 Coloplast case? 14 A. Most of them were rectourethral 14 fistulas, like I mentioned earlier, from No, I do not. Those have all 15 15 radiation damage. been returned to Coloplast. I have reviewed 16 16 There was one that I can them but they all were returned to -- not 17 17 18 recall, again, neurogenic bladder following 18 Coloplast. The legal firm that was representing them. 19 a fall, an inability to work. And that's 19 20 all I can recall. 20 Q. So you reviewed the deposition transcripts and trial transcripts in your 21 And to be honest, there are 21 22 probably other ones, I just cannot recall. 22 Coloplast case? Majority of them early on were definitely 23 23 A. Only the deposition, not the 24 rectourethral fistulas, though. 24 trial. Q. Besides the patent infringement 25 25 Did you make any corrections to Q. Page 39 Page 40 don't -those deposition transcripts? 1 1 2 A. We had -- there were 2 O. It was in a deposition. 3 clarifications so -- an errata or whatever 3 It was in a deposition. Q. I don't see why not. 4 vou call that form was filled out. I read 4 5 over it. There were spelling errors, 5 Was the deposition sealed? 6 grammar errors, those types of things. 6 MR. ANDERSON: Unless it's O. Any substantive changes you 7 7 filed under seal. I don't know. 8 8 recall? BY MR. SNELL: 9 Α. According to me and according to 9 Q. Well, you gave trial testimony. 10 what the lawyer told me --10 A. Q. I don't want to know about the Did you give trial testimony and 11 11 lawyer, just you, in your mind, as a opinions that concerned this errata --12 12 13 surgeon. 13 A. Yes. 14 Α. There would be one where the --14 Q. -- change or issue? 15 the question came up and I misunderstood the 15 No, not the trial, that issue did question and then we corrected it in the not come up. The GMD did not challenge the 16 16 change. I mean, I know what it is. I just form of the deposition. And so we went 17 17 18 back, I went back, and made sure it was 18 want to make sure I can talk about it. clear that this was a misunderstanding. Do you have any basis or reason 19 19 20 Q. Do you recall the question and 20 to believe that the transcript was sealed? 21 your answer? 21 A. No. But I'm not a lawyer so I --22 Yes, I do. 22 MR. ANDERSON: Objection. Α. What is it? Or strike that. 23 23 He wouldn't know that. Q. 24 What was it? 24 THE WITNESS: Yeah. I don't 25 And can I disclose that? I 25 A. know.

	Page	1		Page 42
1	BY MR. SNELL:	1	to the best of your knowledge and belief.	
2	Q. When you reviewed it, did you see	2	A. I don't recall ever doing that,	
3	any designation that the transcript was	3	no. I would think I would remember	
4	confidential?	4	something like that but I don't recall that.	
5	A. Many of the documents many of	5	Q. Besides this matter, are there	
6	the documents had "confidential" on it.	6	any cases in which you expect to testify in	
7	Again, I'm not trying to be	7	with regard to the use of transvaginal mesh?	
8	difficult.	8	A. No.	
9	Q. That's okay.	9	Q. How did you come to be retained	
10	A. I know exactly what it is and I	10	in this litigation?	
11	could tell you. I don't	11	A. Mr. Anderson contacted me.	
12	MR. ANDERSON: If he feels like	12	Q. When was that?	
13	it's ground-breaking stuff, we'll figure it	13	A. September of last year, 2011.	
14	out after the deposition.	14	Q. Besides Mr. Anderson, can you	
15	MR. SNELL: No. Don't worry	15	tell me the names of any other attorneys	
16	about it.	16	you've spoken with on behalf of the	
17	THE WITNESS: Okay.	17	plaintiffs?	
18	BY MR. SNELL:	18	•	
19			A. Mr. Adam Slater, Mr. John Restaino. I mean, if you want to know	
	Q. Have you ever issued any expert	19		
20	Affidavits?	20	everybody that I can think of, Mr. Tom	
21	A. I don't know what that is.	21	Cartmell. And I don't recall. There may	
22	Q. It's a written document where, it	22	have been another one I don't recall. Those	
23	can be like a report except you swear under	23	are the ones that I can think of.	
24	penalty of perjury that things you wrote and	24	Q. Now, you've obviously met	
25	said in the Affidavit are true and correct,	25	Mr. Anderson and Mr. Restaino.	
		2		5 44
1	Page		hours to date, total amount paid was all	Page 44
1	Have you met any of the other	1	hours to date, total amount paid was all	Page 44
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Page 45 Page 46 A. It was on a Saturday roughly --1 testimony at trial? 1 2 2 I'd have to look at the calendar. I would Α. No. 3 3 be able to tell you exactly if I looked at Have you attended any meetings 4 where other experts for the plaintiffs have 4 the calendar. A week and a half or so ago, 5 5 something like that. been present? 6 Experts for the plaintiffs. 6 November 3rd sound right? A. Q. 7 THE WITNESS: That's your side. 7 Again, I'd have to look at the 8 8 calendar. I -- days are all a blur right MR. ANDERSON: Yeah. 9 9 THE WITNESS: I pointed to now. 10 Doctor -- Mr. Anderson. 10 Q. Saturday before last. 11 To the best of my knowledge, 11 Today -- it would have been the Α. no. But we attend -- there's an overlap of Saturday before that. That sounds about 12 12 meetings, uro-gyne and female urology, that right. And she was involved in a conference 13 13 overlaps. I do not recall ever meeting them 14 14 call. Who all was on that conference 15 in person, no. 15 Q. BY MR. SNELL: 16 16 call? O. Have you ever attended any 17 17 Just Mr. Slater, and then 18 meetings focused on this litigation with 18 Dr. Weber showed up half hour into the other experts for the plaintiff? 19 19 conversation. 20 No. 20 Q. What did you say to Dr. Weber? A. It was a half-hour conversation. 21 Have you ever spoken with or 21 Q. communicated with in any manner any other 22 22 I mean, I said hello to start off with and expert for the plaintiff in this litigation? 23 23 then we talked from there. 24 Yeah. With Dr. Weber. 24 Q. Tell me everything you recall discussing with Dr. Weber. 25 When was that? 25 Q. Page 47 Page 48 Okay. I asked her about the 1 MR. RESTAINO: South. 1 2 2 drive from Baltimore down. I wanted to know THE WITNESS: I thought she 3 if there was traffic, which she said there 3 said she drove in from Baltimore. 4 was none. I complimented her on her MR. SNELL: Okay. Just the 4 5 manuscripts that she's written. 5 down threw me off, that's all. 6 Mr. Slater talked a lot and 6 THE WITNESS: Yeah. I'm an 7 wanted to know her opinion on interstitial 7 L.A. boy and Minnesota, so the East Coast 8 8 states are too small. I don't know where cystitis, which she then deferred to me 9 since in urology we tend to deal with that 9 they are. 10 10 BY MR. SNELL: more. 11 I then discussed diagnostic Q. Now, you complimented Dr. Weber 11 criteria for interstitial cystitis. And we on the manuscript she had written; is that 12 12 talked about dates of when she was going to 13 13 correct? give her deposition and then we talked about Manuscripts. 14 14 Α. 15 dates of when I was giving my deposition. 15 Scripts. Q. And that's pretty much all I recall. That And what manuscripts were 16 16 17 17 is all I recall. those? 18 O. You mentioned a conversation 18 A. I'd have to look at the -- the about the drive from Baltimore down? Were exact title of them. The -- there was the 19 19 20 you in Baltimore? 20 original one that she was involved with A. No. No. She -- from what I defining prolapses, and then the other one I 21 21 believe the first author was, it was like 22 recall. Adam said she just drove down from 22 Baltimore. Or up. Where is Baltimore? Chmielewski, something like that. I'd --23 23 again, I'd have to look at the -- I know the 24 Baltimore is south. 24 25 25 content of the paper but not the exact Q. Baltimore is south.

		Page 49			Page 50
1	title.		1	as far as the paper itself, but that's what	
2	Q. Well		2	I was referring to.	
3	<ol> <li>A. It was redefining prolapse.</li> </ol>		3	Q. So you appreciated Dr. Weber's	
4	Q. And how was the prolapse being		4	work in redefining prolapse.	
5	redefined in the paper? Or strike that.		5	A. I think it's a I did not state	
6	How was the prolapse redefined		6	that. That was my underlying intent,	
7	in the manuscript by Dr. Weber?		7	though.	
8	<ul> <li>A. Well, I'd have to get out the</li> </ul>		8	Q. And was the manuscript that	
9	paper and we'd have to go over it.		9	you're referring to Chmielewski,	
10	Q. Just your general recollection.		10	C-H-M-I-E-L-E-W-S-K-I, Walters, Weber, et	
11	A. Well, again, that was a very		11	al., "Re-analysis of a Randomized Trial of	
12	large paper with a lot of details in it, but		12	Three Techniques of Anterior Colporrhaphy	
13	what they were doing and it's in my		13	Using Clinically Relevant Definitions of	
14	expert report in a great amount of detail so		14	Success," Journal of Obstetrics and	
15	that would probably be the best way, to go		15	Gynecology, 2011?	
16	to it. Because off the top of my head, I'm		16	A. That is correct.	
17	not going to do the paper justice.		17	Q. Besides your expert reports in	
18	Q. But you said you recall		18	this case, have you done any other analyses	
19	complimenting Dr. Weber on the manuscript		19	on the use of transvaginal mesh?	
20	that she was involved in where she and		20	MR. ANDERSON: Objection.	
21	others redefined prolapse.		21	Go ahead.	
22	A. No. All I said was, is, I've		22	THE WITNESS: Well,	
23	read your papers and they've I've		23	transvaginal mesh you mean analyses,	
24	appreciated your work. Roughly, that's the		24	what do you mean as far as I need	
25	statement I made. We did not go into detail		25	clarification. Studies? Expert reports?	
	,	Dago E1			Dago E2
1		Page 51	1	A No	Page 52
1	What?	Page 51	1 2	A. No.  O Have you performed any analyses	Page 52
2	What? MR. SNELL: Fair question.	Page 51	2	Q. Have you performed any analyses	Page 52
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2 3 4	What? MR. SNELL: Fair question. BY MR. SNELL: Q. Have you done any other expert	Page 51	2 3 4	Q. Have you performed any analyses comparing the use of transvaginal mesh to other treatment, other surgical treatment	Page 52
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1 2			
	Page 53		Page 54
2	nondescript or nonspecific term.	1	obviously, abdominal mesh. I'd have to look
	We are doing analyses and	2	at my CV to give you a complete list,
3	studies on management of mesh	3	though.
4	complications. And just to clarify your	4	Q. Do you have your CV here today?
5	previous question, that would also include	5	A. I do not have a copy, no.
6	transvaginal POP meshes as well as urinary	6	Q. Have you been involved in any
7	incontinence meshes. And that's dealing	7	prospective studies involving the use of
8	with the laser, dealing with the urologic	8	mesh?
9	complications and perforations. That is an	9	A. No.
10	ongoing process.	10	Q. Have you performed any
11	Q. Have you done any retrospective	11	randomized, controlled trials with the
12	cohort studies involving the use of	12	robotic sacrocolpopexy?
13	transvaginal mesh?	13	A. No.
14	A. Well, if that involves	14	Q. Have you done any prospective
15	anti-incontinence procedures, yes.	15	studies involving the robotic
16	Q. And what study or studies were	16	sacrocolpopexy?
17	those?	17	A. Did you just ask that? I thought
18	A. Those would be presentations	18	it was the same question.
19	we've made over the years. I'd have to get	19	Q. I'm sorry. If I did, I
20	my CV out and review those. But dealing	20	apologize. Let me back it up and just ask
21	with the efficacy the one specific I can	21	it again. It's a little different.
22	remember is the suprapubic ARC or SPARC by	22	A. Okay.
23	EMS. That's the one I can recall.	23	Q. Have you performed any
24	I mean, we've done robotic	24	prospective studies involving robotic
25	sacrocolpopexy data, which is involving,	25	sacrocolpopexy?
	Daga FF		Page 56
1	Page 55 A. No.	1	Page 56 prolapse?
2	Q. When was the last time you	2	A. I don't I don't recall the
3	performed a robotic sacrocolpopexy? I mean	3	details on it.
4	you as the lead surgeon.	4	Q. Do you remember which
5	A. It would have been I'm just	5	manufacturer's polypropylene mesh you used
	doing to give you a guess. It was in the		
6	going to give you a guess. It was in the	6	in this robotic sacrocolpopexy that you
6 7	past month. That may or may not be	6 7	in this robotic sacrocolpopexy that you performed within the last month?
6 7 8	past month. That may or may not be completely accurate. It would have been	6 7 8	in this robotic sacrocolpopexy that you performed within the last month?  A. It was American Medical Systems,
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6 7 8 9 10	past month. That may or may not be completely accurate. It would have been roughly that time frame.  Q. So in the last month you believe	6 7 8 9 10	in this robotic sacrocolpopexy that you performed within the last month?  A. It was American Medical Systems, abbreviated AMS, the IntePro, E-N-T-E capital P-R-O.
6 7 8 9 10 11	past month. That may or may not be completely accurate. It would have been roughly that time frame.  Q. So in the last month you believe you performed a robotic sacrocolpopexy?	6 7 8 9 10 11	in this robotic sacrocolpopexy that you performed within the last month?  A. It was American Medical Systems, abbreviated AMS, the IntePro, E-N-T-E capital P-R-O.  Q. Are you specifically
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6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	past month. That may or may not be completely accurate. It would have been roughly that time frame.  Q. So in the last month you believe you performed a robotic sacrocolpopexy?  A. Well, we're we're a team that performs it. So, yes, I am I am the lead surgeon, I am the primary surgeon, but there is a team. And it's roughly within the past month.  Q. And I assume you used synthetic mesh in that robotic sacrocolpopexy?  A. Correct.  Q. Was that a polypropylene mesh?  A. Correct.	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	in this robotic sacrocolpopexy that you performed within the last month?  A. It was American Medical Systems, abbreviated AMS, the IntePro, E-N-T-E capital P-R-O.  Q. Are you specifically credentialled by the Mayo Clinic to use polypropylene mesh?  A. I'm not aware of there being a credentialling process for use of mesh. I am credentialled for all female urology and prolapse.  Q. So you can perform any procedure you see fit to treat prolapse at Mayo Clinic, under their credentialling guidelines.
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Page 57 Page 58 BY MR. SNELL: 1 prolapse surgeries that include the use of 1 2 synthetic mesh? 2 Q. Did you provide documentation 3 3 A. No. They have credentialled me that you know how to treat prolapse to the 4 or they have approved my credentials for all 4 Mayo Clinic as part of your credentialling? 5 5 prolapse repair, transvaginal or That would have been back in 6 transabdominal, including robotic and 6 2000. And, as I recall, we had to have a 7 laparoscopy, excluding uterine prolapse and 7 letter from my fellowship director 8 8 documenting the number of cases, complexity hysterectomy. 9 9 Q. And did Mayo Clinic credential of cases, variety of cases that I had done 10 you to perform repairs for stress urinary 10 during fellowship to ensure that they had 11 incontinence? 11 reached an acceptable number to show talent 12 Yes. 12 or competency, I suppose. A. O. When you performed this last 13 Did Mayo Clinic specifically 13 credential you for the use of synthetic mesh robotic sacrocolpopexy case involving 14 14 to treat stress urinary incontinence? polypropylene synthetic mesh, did you select 15 15 A. I don't recall -the specific mesh or do you just -- how do 16 16 MR. ANDERSON: Object. you requisition that mesh? 17 17 18 Objection. 18 A. Early on, years ago, so it would have been seven, eight, nine years ago, when 19 19 Go ahead. 20 THE WITNESS: I don't recall 20 we were trying to determine this procedure 21 the specifics of it other than they say I 21 and how we were going to perform it, I reviewed multiple different meshes. 22 have to provide documentation that I know 22 how to treat stress urinary incontinence. I 23 23 Then it goes to an acquisition 24 do not recall specifically a mesh being 24 committee, so to speak, who then contacts 25 involved in there. the various different companies for 25 Page 59 Page 60 purchasing. And there were several that I 1 continued to use Gore-Tex; however, I found 1 2 2 was okay with, and then for financial problems with it of erosion, extrusion --3 reasons the IntePro was chosen. There's... 3 excuse me. Not erosion. Extrusion into the 4 4 vagina. So it was roughly 2002, 2003 is O. And was Prolene mesh one of the 5 5 meshes that you were okay with? when I made the changeover to polypropylene. 6 A. They were all Prolene meshes, 6 Q. Your original training where you 7 7 used Gore-Tex, was that your fellowship? polypropylene meshes. 8 8 A. Correct. MR. ANDERSON: You got that 9 clarification? You said Prolene, he said 9 Q. And that was your fellowship at 10 polypropylene, so maybe we can do --10 Baylor. 11 MR. SNELL: Yeah. A. Baylor, correct. In Houston, 11 12 BY MR. SNELL: 12 Texas. Q. Did you evaluate Gynemesh® PS 13 13 MR. SNELL: Why don't we take a 14 during this review of meshes? 14 little break. 15 To the best of my knowledge, no. 15 (Recess, 11:03-11:18 a.m.) BY MR. SNELL: Why not? 16 Q. 16 17 I wasn't familiar with the O. We spoke a little earlier about A. 17 18 product. 18 the conference call you attended with 19 Q. And this would have been 19 Dr. Weber. 20 approximately seven or eight years ago? 20 What did Dr. Weber say to you? A. It would have been our first A. She didn't speak. I mean, she 21 21 22 robot -- I'll back up. 22 spoke to me but it was nothing of substance I was originally trained to use other than that she felt my knowledge of 23 23 Gore-Tex sacrocolpopexies during my interstitial cystitis and practice was more 24 24 25 fellowship. So when I returned on staff, I 25 involved than hers or just because of my

		-		
1 4	Page	51		Page 62
1	practice, the variations between the two of	1	A. None.	
2	us.	2	Q. And which depositions of the	
3	We talked about patients that I	3	plaintiffs' experts have you read?	
4	had seen, and she had mentioned, you know,	4	A. I'd have to look at the list. My	
5	as far as her seeing patients with pelvic	5	supplemental list would be most thorough.	
6	pain, I believe.	6	Klinge. I'm not pronouncing	
7	Again, it was it was the	7	that correctly, but it's the one I can think	
8		8	• •	
	majority of the time was actually me	9	of off the top of my head. But, again, I'd	
9	talking, not necessarily her.		have to go look at it.	
10	Q. Have you been on any other phone	10	Q. Have you read Dr. Weber's	
11	calls with any of the plaintiffs' experts	11	deposition transcript?	
12	besides this one conference call?	12	A. Yes.	
13	A. No. Just Miss Weber or	13	Q. When did you read Dr. Weber's	
14	Dr. Weber.	14	deposition transcript?	
15	Q. Have you had any other form of	15	<ul> <li>A. It was a few days after or</li> </ul>	
16	communication with any expert for the	16	following the deposition.	
17	plaintiffs?	17	Q. Besides Drs. Klinge and Weber,	
18	A. No. Communication, I mean, I've	18	can you think of any other plaintiffs'	
19	read depositions but no verbal or	19	expert deposition transcripts you've read?	
20	face-to-face communications with any	20	A. I'd have to get my supplemental	
21	plaintiff experts.	21	report out. If we have that, I can go	
22	Q. Any E-mails or letters	22	through the list. Because it's a fairly	
23	A. None.	23	long list. And I have a I have a copy of	
24	Q correspondence between you and	24	my	
25	any other plaintiffs' expert?	25	MR. ANDERSON: No. Just	
23	arry other plainting expert:	23	MIC ANDERSON. No. 3030	
	Page	53		Page 64
1	you've answered the question.	<sup>3</sup>   1	handed me is the official one or the correct	ruge or
2	BY MR. SNELL:	2	one, let's say.	
3	Q. Do you have a copy handy?	3	And so experts excuse me.	
4	A. Yes, I do.	4	Can you ask your question then again?	
			can you ask your question their again:	
	MD ANDEDSAND VOLUMBAN OF the			
5	MR. ANDERSON: You mean of the	5	MR. SNELL: Sure.	
6	supplemental?	6	MR. SNELL: Sure. Let's just make the record	
6 7	supplemental? THE WITNESS: The supplemental.	6 7	MR. SNELL: Sure. Let's just make the record clear.	
6 7 8	supplemental? THE WITNESS: The supplemental. MR. SNELL: Whichever the	6 7 8	MR. SNELL: Sure. Let's just make the record clear. I'm going to mark Deposition	
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6 7 8 9 10	supplemental? THE WITNESS: The supplemental. MR. SNELL: Whichever the doctor wants to look at. MR. ANDERSON: Oh, okay.	6 7 8 9 10	MR. SNELL: Sure. Let's just make the record clear. I'm going to mark Deposition Exhibit Number 2 the supplemental report that I handed you that you have signed, just	
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· .		Page 65			Page 66
1	plaintiffs' experts?		1	adding in the annotations and citations to	
2	A. That would be it.		2	that June 15th, 2012, general report?	
3	Q. When did you review Dr. Klinge's		3	A. Absolutely none that I'm aware	
4	deposition testimony?		4	of.	
5	A. Oh, I can't recall. After		5	Q. And in the June 15th, 2012,	
6	after it became available at some point in		6	general report you did not issue any	
7	·			· · ·	
	time, but I reviewed many in different		7	case-specific opinions with regard to Linda	
8	days. I can't recall.		8	Gross; correct?	
9	MR. SNELL: Off the record for		9	A. That is correct.	
10	a second.		10	Q. And in your June 15th, 2012,	
11	(Discussion off the record.)		11	general report you did not issue any	
12	BY MR. SNELL:		12	case-specific opinions regarding Pamela	
13	Q. While we're talking about		13	Wicker; correct?	
14	reports, let's just make sure I have a full		14	A. Correct.	
15	list of all the reports you've authored in		15	MR. SNELL: For the record, the	
16	this case.		16	defense has filed a Motion to exclude the	
17	The first I have is your June		17	November 7th, 2012, report issued by	
18	15th, 2012, general report in this matter;		18	Dr. Elliott.	
19	is that correct?		19	BY MR. SNELL:	
20	A. Correct. Yes.		20	Q. And, Dr. Elliott, this November	
21	Q. And on November 8th, 2012, it was		21	7th, 2012, report which we marked as Elliott	
22	served on defense counsel and it included		22	Exhibit Number 2, this is the first time	
				· · · · · · · · · · · · · · · · · · ·	
23	annotations or citations; is that correct?		23	you've issued opinions with regard to Linda	
24	A. Correct.		24	Gross; correct?	
25	Q. Are there any changes besides		25	A. Correct.	
					-
		Page 67			Page 68
1	Q. This is the first time you've	Page 67	1	review any depositions in the Pamela Wicker	Page 68
2	issued case-specific opinions with regard to	Page 67	2	case; correct?	Page 68
2	issued case-specific opinions with regard to Mrs. Wicker; correct?	Page 67	2	case; correct? A. Correct.	Page 68
2 3 4	issued case-specific opinions with regard to Mrs. Wicker; correct?  A. Correct.	Page 67	2 3 4	case; correct? A. Correct. Q. Prior to issuing your June 15th,	Page 68
2	issued case-specific opinions with regard to Mrs. Wicker; correct? A. Correct. Q. Before issuing your June 15th,	Page 67	2	case; correct? A. Correct.	Page 68
2 3 4	issued case-specific opinions with regard to Mrs. Wicker; correct?  A. Correct.	Page 67	2 3 4	case; correct? A. Correct. Q. Prior to issuing your June 15th,	Page 68
2 3 4 5	issued case-specific opinions with regard to Mrs. Wicker; correct? A. Correct. Q. Before issuing your June 15th,	Page 67	2 3 4 5	case; correct? A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any	Page 68
2 3 4 5 6	issued case-specific opinions with regard to Mrs. Wicker; correct? A. Correct. Q. Before issuing your June 15th, 2012, general report you did not look at any medical records for Mrs. Gross; correct?	Page 67	2 3 4 5 6	case; correct?  A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any radiology on Linda Gross; correct? A. Correct.	Page 68
2 3 4 5 6 7	issued case-specific opinions with regard to Mrs. Wicker; correct? A. Correct. Q. Before issuing your June 15th, 2012, general report you did not look at any medical records for Mrs. Gross; correct? A. To my knowledge, no.	Page 67	2 3 4 5 6 7	case; correct?  A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any radiology on Linda Gross; correct? A. Correct. Q. Prior to issuing your June 15th,	Page 68
2 3 4 5 6 7 8 9	issued case-specific opinions with regard to Mrs. Wicker; correct?  A. Correct. Q. Before issuing your June 15th, 2012, general report you did not look at any medical records for Mrs. Gross; correct? A. To my knowledge, no. Q. Am I correct?	Page 67	2 3 4 5 6 7 8	case; correct?  A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any radiology on Linda Gross; correct? A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any	Page 68
2 3 4 5 6 7 8 9	issued case-specific opinions with regard to Mrs. Wicker; correct?  A. Correct. Q. Before issuing your June 15th, 2012, general report you did not look at any medical records for Mrs. Gross; correct? A. To my knowledge, no. Q. Am I correct? A. To the best of my knowledge, no,	Page 67	2 3 4 5 6 7 8 9	case; correct?  A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any radiology on Linda Gross; correct? A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any urologic studies on Linda Gross; correct?	Page 68
2 3 4 5 6 7 8 9 10 11	issued case-specific opinions with regard to Mrs. Wicker; correct?  A. Correct. Q. Before issuing your June 15th, 2012, general report you did not look at any medical records for Mrs. Gross; correct? A. To my knowledge, no. Q. Am I correct? A. To the best of my knowledge, no, I did not review any records of Miss Gross.	Page 67	2 3 4 5 6 7 8 9 10 11	case; correct?  A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any radiology on Linda Gross; correct? A. Correct. Q. Prior to issuing your June 15th, 2012, general report you did not review any urologic studies on Linda Gross; correct? A. Correct.	Page 68
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	Page 69			Page 70
1	report.	1	document before?	
2	A. May I see it?	2	A. No, I have not.	
3	Q. Sure.	3	Q. Can you turn towards the back,	
4	MR. ANDERSON: For the record,	4	the appendix? It asks that you bring	
5	I'll just stipulate that I sent that because	5	certain materials to the deposition.	
6	I saw that we had inadvertently left two	6	A. What page are we on? Six?	
7	off, which is what the cover E-mail said	7	<ul><li>Q. Let me get there and follow with</li></ul>	
8	when I sent it to you guys yesterday.	8	you.	
9	THE WITNESS: So your question	9	Let me take a look at it,	
10	I I'm sorry. What's your question?	10	Doctor.	
11	BY MR. SNELL:	11	A. (Witness complies.)	
12	Q. Is this the third and last report	12	Q. Under all this paper, I seem to	
13	or supplement that you have?	13	have lost mine.	
14	A. Yes.	14	So you're correct, Doctor, Page	
15	Q. When you say, I have reviewed the	15	6 through 9 asks that you bring certain	
16	following documents which further support my	16	materials to the deposition.	
17	opinions in this case as set forth in my	17	MR. ANDERSON: Well, just to	
18	original report, when you say "original	18	clarify, I have to object, that it's sent to	
19	report," do you mean your June 15th, 2012,	19	me, so it asks me to bring. And he's	
20	report?	20	already said that he didn't see this.	
21	A. Yes.	21	MR. SNELL: Besides the reports	
22	Q. I'm going to hand you what's been	22	and the compensation information, are there	
23	marked as Exhibit Number 1. It's your	23	any other materials that are forthcoming in	
24	Notice of Deposition.	24	response to the Notice of Deposition?	
25	Have you ever seen that	25	MR. ANDERSON: No.	
	Page 71			Page 72
1	Page 71 MR. SNELL: And what's the	1	Q. Did you learn the location of the	Page 72
1 2		1 2	Q. Did you learn the location of the nerves in the pelvic floor in your medical	Page 72
2 3	MR. SNELL: And what's the		nerves in the pelvic floor in your medical school training?	Page 72
2 3 4	MR. SNELL: And what's the basis for the non-production? MR. ANDERSON: It's my understanding that everything that we are	2 3 4	nerves in the pelvic floor in your medical school training?  A. In a very general way, yes.	Page 72
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	Page 73		Page 74
1	heroin and things.	1	medical school?
2	Then I did a GYN-ONC, which is	2	A. To the best of my knowledge,
3	a GYN cancer rotation, two weeks. And so	3	unfortunately, we're going back 20-some
4	that was dealing with ovarian, uterine,	4	years now, I do not recall any
5	vaginal cancers.	5	anti-incontinence procedures in OB-GYN or
6	Q. Did you see any surgeries	6	it would be GYN, actually or urology.
7	strike that.	7	Q. Did you see any prolapse surgical
8	Did you see any gynecologic	8	procedures during your medical school?
9	surgeries during your medical school?	9	A. I don't recall any, no.
10	A. Yes.	10	Q. You then did an internship in
11	Q. Which were they?	11	general surgery at Mayo in 1994?
12	A. Specifically limited to, again,	12	A. '93 to '94, yeah. One year.
13	GYN-ONC just because hysterectomies from	13	Q. How did you come to choose to do
14	malignancies, debulking procedures for	14	that general surgery internship?
15	malignancies just because that's the	15	A. I didn't have a choice. Every
16	rotation I was assigned to. Others would	16	urology residency you have to do general
17	have different experiences than I.	17	surgery. You either do one or two years or
18	Q. Did you see any C-sections	18	some of them will do one and a half years.
19	performed?	19	At Mayo it's one year. So, again, there was
20	A. In the OB, but that was not GYN.	20	no choice in the matter.
21	Q. Did you see episiotomies	21	Q. And what did that internship
22	performed?	22	consist of? What types of surgeries did you
23	A. Yes.	23	see or were you involved in?
24	Q. Did you see surgeries for stress	24	A. You do rotations varying between
25	urinary incontinence performed during	25	6 to 12 weeks in vascular, colorectal,
1	Page 75	1	Page 76
1 2	transplant, trauma, and there's something else. There was one more rotation in there.	1 2	Q. Did you see or were you involved in any hernia surgeries that involved mesh
3	I can't recall. There's one more rotation.	3	during your internship?
4	It was basically just covering the entire	4	A. I don't recall any.
5	abdomen.	5	Q. Did you see or were you involved
6	Q. And did you perform surgeries	6	in any prolapse surgeries during that
7	during your internship or were you just	7	internship?
8	watching or helping out in some manner?	8	A. For pelvic organ prolapse?
9	A. You're an assistant. You may	9	Q. Yes.
10	perform put in some stitches, but you're	10	A. No.
11	not doing much.	11	Q. You hesitated there for a second.
12	Q. During your internship in general	12	Was there some type of other
13	surgery did you see any hernia surgeries?	13	prolapse procedure that you saw during your
14	A. Yes.	14	internship?
15	Q. Did you help assist in any	15	A. Well, there's, you know, mitral
16	hernia	16	valve prolapse, diaphragmatic.
17	A. Yes.	17	Prolapse is just a generic
18	Q hernia surgeries?	18	term, so I just wanted to make sure I was
19	A. Excuse me. Yes.	19	clear what you were talking about.
20	Q. Did these hernia surgeries	20	Q. That's fair. Thank you for
21	involve the use of mesh?	21	clarifying that.
22	A. To the best of my recollection,	22	I'm not here talking about
23	no. And I think that's fairly accurate. It	23	mitral valve prolapse or any other valve
	was an older general surgeon who did not	24	prolapse. When I say prolapse today and
24	1140 411 0140 90110141 041 90011 11110 414 1101		
2 <del>4</del> 25	believe in meshes, actually.	25	tomorrow, I just want you to assume that I'm

	Pa	ge 77		Pa	age 78
1	talking about pelvic organ prolapse. Okay?	-	1	A. Not that I recall, no.	Ĭ
2	A. I'll still ask for clarification.		2	Q. During your internship were you	
3	Q. That's fine. But		3	trained on the location of blood vessels in	
	•				
4	A. Sure.		4	the pelvic floor?	
5	Q I'm going to tell you I'm not		5	A. Yes.	- 1
6	getting into mitral valves.		6	Q. During your internship were you	- 1
7	Did you see any surgeries for		7	trained on the location of ligaments and	- 1
8	urinary incontinence during your internship?		8	connective tissues within the pelvic floor?	- 1
9	A. Male or female?		9	A. Yes.	- 1
10	Q. Either.	1	10	Q. For example, were you trained on	- 1
11	A. Probably probably male,	1	11	the location of the sacrospinous ligament	- 1
12	because you do actually do a six-week		12	during your internship?	- 1
13	urology rotation. I can't recall exactly.		13	A. I can't state that specific	- 1
14	The staff I worked with did deal with male		14	ligament, but in colorectal surgery I was	- 1
15	incontinence.		15		- 1
				working in the same general region, and the	- 1
16	Q. During your internship in general		16	aggressive surgeries with malignancies,	- 1
17	surgery were you trained on anatomy?		17	those ligaments in that general region would	
18	A. Yes.		18	have been exposed and shown.	- 1
19	Q. And you were trained on that		19	Q. And that would include the	- 1
20	anatomy as it has bearing upon performing		20	A. Or	- 1
21	surgical procedures in those areas?	2	21	Q. I'm sorry. I didn't mean to cut	- 1
22	A. Correct.	2	22	you off. Were you going to say something	- 1
23	Q. During your internship were you	2	23	else?	- 1
24	trained on the location of nerves in the	2	24	A. I was. I forgot what I was going	- 1
25	pelvic floor?	2	25	to say, though.	- 1
	Par	ge 79		Pa	age 80
1		ge 79	1		age 80
1 2	Q. I apologize.			Q. Is that a standard five-year	age 80
2	<ul><li>Q. I apologize.</li><li>Would that have included the</li></ul>		2	Q. Is that a standard five-year program or did why did it take five	age 80
2 3	Q. I apologize. Would that have included the sacrospinous ligament?		2 3	Q. Is that a standard five-year program or did why did it take five years?	age 80
2 3 4	Q. I apologize. Would that have included the sacrospinous ligament? A. Yes.		2 3 4	Q. Is that a standard five-year program or did why did it take five years?  A. Well, the residency, urology	age 80
2 3 4 5	<ul><li>Q. I apologize.</li><li>Would that have included the sacrospinous ligament?</li><li>A. Yes.</li><li>Q. Would that have included the</li></ul>		2 3 4 5	Q. Is that a standard five-year program or did why did it take five years?  A. Well, the residency, urology residency, when I did it, was a total of six	age 80
2 3 4 5 6	Q. I apologize. Would that have included the sacrospinous ligament? A. Yes. Q. Would that have included the arcus tendineus?		2 3 4 5 6	Q. Is that a standard five-year program or did why did it take five years?  A. Well, the residency, urology residency, when I did it, was a total of six years, so from start to finish is six years.	age 80
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			· 
	Page 81	_	Page 82
1	would you give during those surgeries?	1	observe or participate in during your
2	A. That depends upon your level of	2	urologic surgery residency between 1994 and
3	training. At times, you will do minimal, at	3	1999?
4	times, you'll do nearly the entire case.	4	A. Anterior colporrhaphy, posterior
5	That depends upon your skill level and the	5	colporrhaphy, McCall's culdoplasty or Mayo
6	surgeon you happen to be working with.	6	culdoplasty. There's going to be subtle
7	Q. For you	7	variations between those two. That should
8	A. That would depend, because I	8	be it.
9	can't answer the question specifically.	9	Q. So during your residency you
10	Because if I'm in the second year, I'm going	10	didn't observe or perform any sacrospinous
11	to do a little bit; if I'm a chief, six	11	ligament fixations?
12	years, I will do a lot or essentially the	12	A. No.
13	entire case with supervision, obviously.	13	Q. During your residency you didn't
14	Q. So as you got more and more	14	perform any sacrocolpopexies?
15	experience, you were allowed to do more and	15	A. No.
16	more of the procedure.	16	Q. Do you know why you didn't
17	<ul> <li>A. As your experience and skill</li> </ul>	17	perform any sacrocolpopexies at Mayo during
18	level advanced, you did more.	18	your residency?
19	Q. Now, with prolapse surgeries	19	A. During my training, the female
20	during your residency does the same hold	20	urology was somewhat in its infancy. The
21	true, basically, that as your experience and	21	staff was not trained in that so did not do
22	skill level increase, you are able to	22	that, and they went to the GYN department to
23	perform more and more of the case?	23	do those.
24	A. Correct.	24	Q. During your residency did you
25	Q. What prolapse surgeries did you	25	have occasion to go to the GYN group and
١,	Page 83	1	Page 84
1	observe those surgeries for prolapse?	1	who trained you on the prolapse surgeries
2	A. I don't recall ever doing that.	2	during your residency?
3	Q. During your residency what stress	3	A. Dr. Lightner. Dr. Deborah
4 5	urinary incontinence procedures were you	4 5	Lightner.
	trained on?	6	Q. How do you spell her last name?
6 7	A. Artificial urinary sphincter, Raz	7	A. It's Lightner.
_	urethropexy, and autologous pubovaginal	_	Q. Okay. A. L-I-G-H-T-N-E-R.
8	sling, cadaveric pubovaginal sling.	8	
9	Q. During your residency can you estimate the number of colporrhaphies that	9	Q. And then you went and did your fellowship at Baylor that we earlier
10 11	you participated in?	10 11	discussed with regard to neurology,
12	, , ,	12	
13	A. Yeah. My female urology rotation	13	urodynamics and voiding dysfunction?  A. Correct.
14	was 1997 so I'll only give you a rough estimate. Maybe ten. And you asked,	13 14	Q. Why did you seek to do that
15	·	15	- '
16	actually anterior?	16	fellowship?  A. That was I was asked to come
	Q. I just asked for either, for		
17 18	either anterior or posterior.  A. Oh. Combined, roughly ten	17	back on staff, and so the chair and executive committee selected the program for
ΙTΟ		18	· •
	· · · · · · · · · · · · · · · · · · ·	10	mo to go to which thou would tool would and
19	anterior and ten posterior.	19 20	me to go to which they would feel would give
19 20	anterior and ten posterior. Q. How about the number of McCall's	20	me the best education.
19 20 21	anterior and ten posterior. Q. How about the number of McCall's culdoplasty or Mayo culdoplasty, as you	20 21	me the best education. Q. Can you tell me what that course
19 20 21 22	anterior and ten posterior.  Q. How about the number of McCall's culdoplasty or Mayo culdoplasty, as you termed it?	20 21 22	me the best education. Q. Can you tell me what that course I'm sorry that fellowship course
19 20 21 22 23	anterior and ten posterior.  Q. How about the number of McCall's culdoplasty or Mayo culdoplasty, as you termed it?  A. It would be probably two or	20 21 22 23	me the best education. Q. Can you tell me what that course I'm sorry that fellowship course consisted of?
19 20 21 22 23 24	anterior and ten posterior.  Q. How about the number of McCall's culdoplasty or Mayo culdoplasty, as you termed it?  A. It would be probably two or three.	20 21 22 23 24	me the best education. Q. Can you tell me what that course I'm sorry that fellowship course consisted of? A. Uh-huh. It is voiding
19 20 21 22 23	anterior and ten posterior.  Q. How about the number of McCall's culdoplasty or Mayo culdoplasty, as you termed it?  A. It would be probably two or	20 21 22 23	me the best education. Q. Can you tell me what that course I'm sorry that fellowship course consisted of?

		1		
	Page 85		F	Page 86
1	Dr. Tim Boone, B-O-O-N-E, and where he	1	MR. RESTAINO: And write it	
2	managed the voiding dysfunction,	2	sloppily.	
3	incontinence and neuroanatomy. He was a	3	THE WITNESS: And write it	- 1
4	neuro Ph.D., M.D. And then all the	4	sloppily, yeah.	- 1
5	prolapses I did with the GYNs while he	5	It's a closure of the vagina,	- 1
6	managed the incontinence. That's	6	essentially.	- 1
7	specifically why the program was chosen for	7	BY MR. SNELL:	- 1
8	me.	8	Q. And the perineo I missed it.	- 1
9	Q. And the prolapse surgeries you	9	A. Oh, perineorrhaphy. I'd have to	- 1
10	did during your fellowship were what?	10	write that one out to be able to	- 1
11	A. Well, we we we did them	11	Q. Well, what did that consist of?	- 1
12	all: Anterior/posterior colporrhaphies, the	12	You don't have to write it out.	- 1
13	McCall's culdoplasty, sacrospinous fixation,	13	A. That is a rebuilding of the	- 1
14	abdominal sacrocolpopexy, perineorrhaphies,	14	peroneal body, usually which has been	- 1
15	colpocleisis.	15	destroyed is a harsh term attenuated,	- 1
16	Q. Can you spell those last two for	16	thinned out due to multiple childbirths. So	- 1
17	the court reporter?	17	you rebuild it. It's right at the introitus	- 1
18	A. Colpocleisis is a tough one.	18	of the vagina on the posterior aspect.	- 1
19	C-O-L-P-O-C-E-I-S. And that's not even	19	Q. And who was the surgeon who	- 1
20	going to be correct, actually.	20	trained you on these prolapse surgeries?	- 1
21	MR. ANDERSON: C-L-E-I-S-I-S.	21	· · · · · · · ·	- 1
22			A. Multiple surgeons because I	- 1
	THE WITNESS: Do you know what?	22	worked with the GYN department at Baylor. I	- 1
23	It's a tough one. There's E's and I's	23	worked specifically with the chair, who I	- 1
24	everyone. That's why we just say	24	can't recall his name, and then another	- 1
25	colpocleisis, say it fast and	25	surgeon at Texas Woman's Hospital, again,	- 1
	D 07			
	Page 87			Page 88
1	who I cannot recall his name top of my head.	1	A. Yes.	Page 88
2	who I cannot recall his name top of my head. Dr. Cone. Excuse me. I don't know his	2	A. Yes. Q. Which ones?	Page 88
2 3	who I cannot recall his name top of my head. Dr. Cone. Excuse me. I don't know his first name. Who he is the one who mainly	2	<ul><li>A. Yes.</li><li>Q. Which ones?</li><li>A. Autologous pubovaginal sling,</li></ul>	Page 88
2 3 4	who I cannot recall his name top of my head. Dr. Cone. Excuse me. I don't know his first name. Who he is the one who mainly taught me the sacrocolpopexy. But there	2 3 4	<ul><li>A. Yes.</li><li>Q. Which ones?</li><li>A. Autologous pubovaginal sling,</li><li>cadaveric pubovaginal sling, artificial</li></ul>	Page 88
2 3 4 5	who I cannot recall his name top of my head. Dr. Cone. Excuse me. I don't know his first name. Who he is the one who mainly taught me the sacrocolpopexy. But there were other surgeons in there.	2 3 4 5	<ul><li>A. Yes.</li><li>Q. Which ones?</li><li>A. Autologous pubovaginal sling, cadaveric pubovaginal sling, artificial urinary sphincter.</li></ul>	Page 88
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1	A. Yeah. I don't perform		A. Correct.	
2	hysterectomies, but yes.	2	Q. All prolapse surgeries have a	
3	Q. You have been trained and you are	3	potential risk of dyspareunia; correct?	
4	aware as a medical physician that there are	4	A. Yes.	
5	risks attendant to hysterectomy.	5	Q. All prolapse surgeries have a	
6	A. Yes.	6	potential risk of pelvic pain; correct?	
7	Q. There's risks with episiotomies?	7	A. Yes.	
8	A. Yes.	8	Q. What was the first mesh or graft	
9	Q. There's risks with Caesarean	9	material you ever used during your training?	
10	section surgery?	10	A. The SPARC by AMS.	
11	A. Yes.	11	Q. And when was that?	
12	Q. Is it correct that all prolapse	12	A. Roughly 2002.	
13	surgeries have a risk of bleeding?	13	I'm going to have to actually	
14	A. Yes.	14	after reading this go back and correct my	
15	<ul><li>Q. All prolapse surgeries have a</li></ul>	15	answer because you said first mesh or graft	
16	risk of infection?	16	material you ever used during your training.	
17	A. Yes.	17	I understood the question as incontinence.	
18	Q. All prolapse surgeries have a	18	During my training, we used	
19	risk to injury to other organs?	19	Gore-Tex on sacrocolpopexies. That's what I	
20	A. Yes.	20	was originally trained with. So I	
21	Q. All prolapse surgeries have a	21	misunderstood your question.	
22	risk to nerves?	22	Q. That's okay.	
23	A. Yes.	23	The SPARC was for urinary	
24	Q. All prolapse surgeries have a	24	incontinence; correct?	
25	risk of pain; correct?	25	A. Correct.	
				$\neg$
	Page 91		Page 9	92
1	Q. First time you performed a	1	The sacrocolpopexy procedures	92
2	Q. First time you performed a sacrocolpopexy was during your fellowship at	2	The sacrocolpopexy procedures you performed with Gore-Tex mesh to treat	92
2	Q. First time you performed a sacrocolpopexy was during your fellowship at Baylor; correct?	2	The sacrocolpopexy procedures you performed with Gore-Tex mesh to treat prolapse during your fellowship was between	92
2 3 4	Q. First time you performed a sacrocolpopexy was during your fellowship at Baylor; correct?  A. Correct. Yes.	2 3 4	The sacrocolpopexy procedures you performed with Gore-Tex mesh to treat prolapse during your fellowship was between 1999 and 2000; correct?	92
2 3 4 5	Q. First time you performed a sacrocolpopexy was during your fellowship at Baylor; correct?  A. Correct. Yes. Q. And who trained you on performing	2 3 4 5	The sacrocolpopexy procedures you performed with Gore-Tex mesh to treat prolapse during your fellowship was between 1999 and 2000; correct?  A. Correct. To June June 31st	92
2 3 4 5 6	Q. First time you performed a sacrocolpopexy was during your fellowship at Baylor; correct? A. Correct. Yes. Q. And who trained you on performing the sacrocolpopexy with the Gore-Tex mesh?	2 3 4 5 6	The sacrocolpopexy procedures you performed with Gore-Tex mesh to treat prolapse during your fellowship was between 1999 and 2000; correct?  A. Correct. To June June 31st June 30th of 2000. That's when my	92
2 3 4 5 6 7	Q. First time you performed a sacrocolpopexy was during your fellowship at Baylor; correct?  A. Correct. Yes. Q. And who trained you on performing the sacrocolpopexy with the Gore-Tex mesh? A. Dr. Cone, C-O-N-E, at Texas	2 3 4 5 6 7	The sacrocolpopexy procedures you performed with Gore-Tex mesh to treat prolapse during your fellowship was between 1999 and 2000; correct?  A. Correct. To June June 31st June 30th of 2000. That's when my fellowship ended.	92
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1	fellowship, when you performed	1	successfully?	
2	sacrocolpopexies with Gore-Tex mesh, you	2	A. No.	
3	were aware that there was a potential risk	3	Q. Have you ever guaranteed such	ĺ
4	of mesh exposure; correct?	4	performance?	
5	A. Yes.	5	A. As I said, no.	
6	Q. And you were aware during that	6	Q. Have you ever guaranteed patients	
7	same time period of your fellowship that	7	that they will not have complications in	
8	mesh exposure with Gore-Tex mesh performed	8	association with a prolapse surgery?	ĺ
9	during sacrocolpopexy could lead to the need	9	A. No.	
10	for re-operation.	10	Q. Why is that?	
11	A. Yes.	11	A. Because you cannot guarantee it.	
12	Q. And you are aware in 1999 and	12	Q. And as a surgeon, you know that	
13	2000 that any time you place a synthetic	13	any time you perform a prolapse surgery,	
14	mesh, be it Gore-Tex or another mesh	14	re-operation is a potential risk going into	
15	material, that there is a potential risk of	15	it; correct?	İ
16	mesh exposure; correct?	16	A. That is correct.	İ
17	A. Yes, you're right.	17	Q. And that can be a re-operation	
18	Q. Do you guarantee success in the	18	because of a failure of the prolapse surgery	ĺ
19	surgeries you perform with your patients?	19	in performing its intended job to hold the	
20	A. No.	20	prolapse; correct?	İ
21	Q. Why is that?	21	A. I I assume you're asking	ĺ
22	A. Because I cannot guarantee	22	because of failure reoccurrence? Yes.	
23	success.	23	Q. And there can also be need for	ĺ
24	Q. Can any prolapse procedure be	24	re-operation because a complication has	
25	guaranteed to be performed 100 percent	25	occurred which necessitates further surgical	
	Page 95			Page 96
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1 Looking back at it, we realized there was 2 contraction, but we called it fibrosis in 3 our manuscripts. 4 Q. So when you did these studies 5 what animal model was this? 6 A. Rabbit. 7 Q. Rabbit? 8 When you did these animal 9 studies in the rabbit model back in 2004 or 10 2005, you saw fibrosis with the 11 polypropylene mesh?  Page 97  1 Q. Did you ever write what 2 journal were they published in? 3 A. I'd have to look. General I 4 would suspect General Urology and Use of the editor or an errata to your studies 8 to today, as we sit here today, to say 9 we previously described as fibrosis I 10 believe to be mesh contraction? 11 A. No.	Jrology. es up
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9 studies in the rabbit model back in 2004 or 10 2005, you saw fibrosis with the 2005, you saw fibrosis with the 2005, you saw fibrosis with the 2005, you saw fibrosis with the 2005, you saw fibrosis with the 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005, you saw fibrosis with the 2004 or 2005	
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10 2005, you saw fibrosis with the 10 believe to be mesh contraction? 11 polypropylene mesh? 11 A. No.	now
11 polypropylene mesh? 11 A. No.	
, ,, ,,	
12 A. Correct. 12 Q. Why not?	
13 Q. And in these rabbit studies in 13 A. Others have done it for me.	
14 2004 or 2005 that involved polypropylene 14 Q. Who has done it for you with	1
15 mesh you didn't call what you saw mesh 15 regard to those two articles?	ı
16 contraction; correct? 16 A. Dr. Chris Winters, president of	of.
17 A. Correct. 17 the SUFU, Society of Urodynamics ar	
, , , , , , , , , , , , , , , , , , , ,	
expert for the plaintiffs, it's your 19 about, quoting that paper as one of to testimony that now you believe what you saw 20 earliest manuscripts talking about fib	
, , , , , , , , , , , , , , , , , , , ,	IUSIS
	to.
22 A. Correct. 22 Q. He talks about it with regard	ιο
Q. Did you ever do any publications 23 fibrosis and contraction?	
24 on these rabbit studies? 24 A. Uh-huh. Uh-huh. Yes.	-2
25 A. Yes. Two. 25 MR. ANDERSON: Is that yes	of.
Page 99	Page 100
1 THE WITNESS: Yes. Yes. 1 When was Gore-Tex mesh	3.
2 Correct. 2 FDA-cleared for the treatment of pelv	vic
3 BY MR. SNELL: 3 organ prolapse?	
4 Q. What's his name? 4 A. I have no idea.	
5 A. Dr. Christian Winters, the 5 Q. When you performed the	
6 president of the Society of Urodynamics and 6 sacrocolpopexies with Gore-Tex mesi	h to treat
7 Female Urology. 7 prolapse in 1999 to 2001, had it been	
8 Then there's Dr. Gregory Bales 8 FDA-cleared for the treatment of pro	
9 at the University of Chicago, who I've heard 9 MR. ANDERSON: Objection.	•
10 lectures quoting that paper. Those are the 10 Go ahead.	
11 two I can think of off the top of my head. 11 THE WITNESS: I have no id	lea
12 Q. When did you first perform a 12 I would have trusted the company the	
13 hernia surgery involving mesh, if ever? 13 been.	iat it riau
	DC was
	ioi tile
17 the Gore-Tex mesh with sacrocolpopexy?   17 treatment of prolapse; correct?	
10 A Voc I don't remember when I 10 MD ANDEDCON: Objection	
18 A. Yes. I don't remember when I 18 MR. ANDERSON: Objection.	
19 changed over to using polypropylene. It 19 Go ahead.	
19 changed over to using polypropylene. It 20 would have been, as I mentioned earlier, 20 THE WITNESS: I didn't known	W
19 changed over to using polypropylene. It 20 would have been, as I mentioned earlier, 21 2002, 2003. So, again, I don't recall 21 Go ahead. 20 THE WITNESS: I didn't known and the company of the compan	W
19 changed over to using polypropylene. It 20 would have been, as I mentioned earlier, 21 2002, 2003. So, again, I don't recall 22 exactly when.  19 Go ahead. 20 THE WITNESS: I didn't known in the control of the cont	w
19 changed over to using polypropylene. It 20 would have been, as I mentioned earlier, 21 2002, 2003. So, again, I don't recall 22 exactly when. 23 Q. When you used the Gore-Tex mesh 29 Go ahead. 20 THE WITNESS: I didn't know 21 that. 21 gy MR. SNELL: 22 BY MR. SNELL: 23 Q. You didn't know that?	w
19 changed over to using polypropylene. It 20 would have been, as I mentioned earlier, 21 2002, 2003. So, again, I don't recall 22 exactly when.  19 Go ahead. 20 THE WITNESS: I didn't know 21 that. 22 BY MR. SNELL:	

	Page 101		the colored color	Page 102
1	Gynemesh® PS was the first mesh cleared by	1	the prolapse; correct?	
2	the FDA for the treatment of prolapse?	2	A. Yes.	
3	A. I've already answered that	3	Q. And women with prolapse can have	
4	question.	4	dyspareunia at baseline with that	
5	Q. I'm asking a specific date now to	5	associated with that prolapse; correct?	
6	see if this refreshes your recollection.	6	A. Yes.	
7	A. It does not, no.	7	Q. And some women are actually not	
8	Q. Would you agree that pelvic organ	8	sexually active because of the effect their	
9	prolapse can be burdensome to many women?	9	prolapse has upon them; correct?	
10	A. Absolutely.	10	A. Yes.	
11	Q. Would you agree that it can	11	Q. And that can be because of the	
12	affect their quality of life?	12	physical effects of the prolapse; correct?	
13	A. Absolutely.	13	A. As one of the factors, yes.	
14	Q. Women with prolapse can report	14	Q. But also the way the woman feels	
15	feelings of heaviness or pressure?	15	about herself because of the prolapse;	
16	A. Correct.	16	correct?	
17	Q. They can report the feeling of a	17	A. Absolutely.	
18	bulge or see an actual protrusion from their	18	Q. And you know that because of your	
19	vagina; correct?	19	training; right?	
20	A. Correct.	20	A. Experience.	
21	Q. And this can be distressing to	21	Q. You know that because of your	
22	many women; correct?	22	experience?	
23	A. Absolutely.	23	A. Yes.	
24	Q. Patients with prolapse can have	24	Q. But also your training; correct?	
25	interference with their sexual activity from	25	A. They're one and the same.	- 1
	,		, , , , , , , , , , , , , , , , , , ,	
	Page 103			Page 104
1	Q. Patients with prolapse can have	1	may be not sexually active because of	
2	pain in their pelvic floor from changes to	2	partner factors as opposed to the factor	
3	their pelvic floor musculature; correct?	3	specific to the prolapse; correct?	
4	A. Pain is highly unlikely to be	4	A. Okay. Thank you. I understand	
5	associated with pelvic organ prolapse, and	5	the question now.	
6	in the exception, there can be pain. That	6	Yes, you are correct.	
7	is waws		res, you are correct.	
_	is rare.	7	Q. Treatment options for prolapse	
8	Q. Some patients with prolapse are			
8 9		7	Q. Treatment options for prolapse	
	Q. Some patients with prolapse are	7 8	Q. Treatment options for prolapse involve conservative and surgical measures;	
9	Q. Some patients with prolapse are not sexually active because of factors	7 8 9	Q. Treatment options for prolapse involve conservative and surgical measures; correct?	
9 10	Q. Some patients with prolapse are not sexually active because of factors associated with their partner; correct?	7 8 9 10	<ul><li>Q. Treatment options for prolapse involve conservative and surgical measures; correct?</li><li>A. Yes.</li></ul>	
9 10 11	Q. Some patients with prolapse are not sexually active because of factors associated with their partner; correct?  A. There are a lot of variables in	7 8 9 10 11	<ul> <li>Q. Treatment options for prolapse involve conservative and surgical measures; correct?</li> <li>A. Yes.</li> <li>Q. They involve the use of what's</li> </ul>	
9 10 11 12	Q. Some patients with prolapse are not sexually active because of factors associated with their partner; correct?  A. There are a lot of variables in that one.	7 8 9 10 11 12	<ul> <li>Q. Treatment options for prolapse involve conservative and surgical measures; correct?</li> <li>A. Yes.</li> <li>Q. They involve the use of what's called a pessary; correct?</li> </ul>	
9 10 11 12 13	Q. Some patients with prolapse are not sexually active because of factors associated with their partner; correct?  A. There are a lot of variables in that one.  Some patients with prolapse are	7 8 9 10 11 12 13	<ul> <li>Q. Treatment options for prolapse involve conservative and surgical measures; correct?</li> <li>A. Yes.</li> <li>Q. They involve the use of what's called a pessary; correct?</li> <li>A. Yes, that is one option.</li> </ul>	
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9 10 11 12 13 14 15	Q. Some patients with prolapse are not sexually active because of factors associated with their partner; correct?  A. There are a lot of variables in that one.  Some patients with prolapse are not sexually active because of factors associated with their partner. Are we talking male or female? I mean, I guess I'm	7 8 9 10 11 12 13 14 15	<ul> <li>Q. Treatment options for prolapse involve conservative and surgical measures; correct?</li> <li>A. Yes.</li> <li>Q. They involve the use of what's called a pessary; correct?</li> <li>A. Yes, that is one option.</li> <li>Q. Do you believe that option is appropriate in all patients?</li> </ul>	
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1	prolapse tends not to improve. It does not	1	A. Yes.
2	necessarily worsen, however.	2	Q. There can be vaginal odor
3	BY MR. SNELL:	3	associated with the use of pessaries?
4	Q. Some women do not want to use a	4	A. Yes.
5	pessary; correct?	5 6	Q. There can be ulceration
6 7	A. Absolutely.	7	associated with the use of a pessary?  A. Yes.
8	Q. And women who have pessaries need to be seen by their physician periodically	8	Q. There can be bleeding associated
9	to check on the pessary; correct?	9	with the use of a pessary?
10	A. Correct.	10	A. Yes.
11	Q. And how often do you see your	11	Q. There can be tissue erosion
12	patients who use pessaries	12	associated with the use of a pessary;
13	A. I don't see them	13	correct?
14	Q for the maintenance of them?	14	A. Yes.
15	A. I don't see them I don't	15	Q. And these are all potential
16	implant or deal with pessaries.	16	complications from a pessary that you've
17	Q. Okay.	17	known about since the time of your training?
18	A. I refer them to our urogynecology	18	A. Yes.
19	colleagues.	19	Q. And these symptoms may lead a
20	Q. And you know some women are given	20	woman to discontinue the use of a pessary;
21	pessaries as an option and they just refuse	21	correct?
22	to use a pessary; correct?	22	A. Yes.
23	A. You're correct.	23	Q. Do pessaries need to be removed
24	Q. There can be vaginal discharge	24	and cleaned on a regular basis?
25	with pessaries?	25	A. Yes.
	Page 107		Page 108
1	Q. The Gore-Tex mesh you used	1	between 1999 and 2001?
2	Q. The Gore-Tex mesh you used between 1999 and 2001, who was the	2	between 1999 and 2001? A. I don't recall.
2	Q. The Gore-Tex mesh you used between 1999 and 2001, who was the manufacturer of that?	2	between 1999 and 2001? A. I don't recall. MR. ANDERSON: We've been going
2 3 4	Q. The Gore-Tex mesh you used between 1999 and 2001, who was the manufacturer of that?  A. Gore-Tex.	2 3 4	between 1999 and 2001? A. I don't recall. MR. ANDERSON: We've been going about an hour and 20 and I think lunch will
2 3 4 5	Q. The Gore-Tex mesh you used between 1999 and 2001, who was the manufacturer of that?  A. Gore-Tex. Q. And what was the porosity of that	2 3 4 5	between 1999 and 2001? A. I don't recall. MR. ANDERSON: We've been going about an hour and 20 and I think lunch will be here any minute, so I'm not telling you
2 3 4 5 6	Q. The Gore-Tex mesh you used between 1999 and 2001, who was the manufacturer of that?  A. Gore-Tex. Q. And what was the porosity of that Gore-Tex mesh that you used between 1999 and	2 3 4 5 6	between 1999 and 2001?  A. I don't recall.  MR. ANDERSON: We've been going about an hour and 20 and I think lunch will be here any minute, so I'm not telling you to stop now, I'm just suggesting that
2 3 4 5 6 7	Q. The Gore-Tex mesh you used between 1999 and 2001, who was the manufacturer of that?  A. Gore-Tex. Q. And what was the porosity of that Gore-Tex mesh that you used between 1999 and 2001?	2 3 4 5 6 7	between 1999 and 2001?  A. I don't recall.  MR. ANDERSON: We've been going about an hour and 20 and I think lunch will be here any minute, so I'm not telling you to stop now, I'm just suggesting that whenever you get to a good break, I think
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. The Gore-Tex mesh you used between 1999 and 2001, who was the manufacturer of that?  A. Gore-Tex. Q. And what was the porosity of that Gore-Tex mesh that you used between 1999 and 2001?  A. I don't know. Q. What was the flexural rigidity of that Gore-Tex mesh you used between 1999 and 2001?  A. I don't  MR. ANDERSON: Objection. Go ahead.  THE WITNESS: I don't know.  BY MR. SNELL: Q. What was the burst strength of that Gore-Tex mesh you used between 1999 and 2001?  MR. ANDERSON: Objection. Go ahead. THE WITNESS: I don't know.  BY MR. SNELL:	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. I don't recall.  MR. ANDERSON: We've been going about an hour and 20 and I think lunch will be here any minute, so I'm not telling you to stop now, I'm just suggesting that whenever you get to a good break, I think it's probably a good time to break. But continue, please. BY MR. SNELL:  Q. During your fellowship you performed sacrospinous ligament fixation surgeries to treat prolapse; correct?  A. I assisted on those cases, yes. Q. And you are aware that any time one is targeting the sacrospinous ligament, there is a potential risk to the pudendal nerves; correct?  A. Yes. Q. And you knew this back in 1999 to 2000; correct? A. Yes. Q. And you know there's also a

	Page 109		Page 110
1	correct?	1	Q. Is there a particular textbook or
2	A. Yes.	2	surgical textbook that you received during
3	Q. And you knew this back in 1999	3	your fellowship that you used?
4	and 2000; right?	4	A. I don't recall ever receiving
5	A. Yes.	5	one, no. I mean, I may have. I don't
6	Q. And when you were trained on	6	recall it.
7	targeting the sacrospinous ligament	7	Q. Did you recall looking at
8	strike that.	8	surgical textbooks during your fellowship to
9	When you were trained on	9	aid or assist you in performing prolapse
10	targeting the sacrospinous ligament during	10	surgeries?
11	the fixation surgery you were assisting in	11	A. Say no for prolapse surgeries.
12	in 1999 and 2000, you were trained to target	12	Q. Were there general urologic or
13	the sacrospinous ligament two finger	13	gynecologic surgical textbooks you used
14	breadths medial to the ischial spine;	14	during your fellowship?
15	correct?	15	A. Yeah. Raz's I would suspect
16	A. Actually, I don't recall because	16	would be Raz's Transvaginal Surgery text.
17	I never did pass the needle. The staff	17	Q. Back in 1999 and 2000, when you
18	didn't feel it was safe for training on it,	18	did your fellowship, when you performed the
19	we only did a few, and so I never did it.	19	sacrocolpopexy, these were open abdominal
20	Q. No one ever said this is how far	20	sacrocolpopexies, I take it?
21	you should go medial to the ischial spine	21	A. Correct.
22	when placing a suture in the sacrospinous	22	Q. During your fellowship you were
23	ligament fixation?	23	not trained on laparoscopic sacrocolpopexy;
24	A. I'm sure they had mentioned it.	24	correct?
25	I don't recall it.	25	A. Correct.
	Page 111		Page 112
1	Q. During your fellowship you	1	A. Yes.
2	learned that there was a risk of bowel	2	Q. And during your residency and
3	adhesion with sacrocolpopexy; correct?	3	
			fellowship you were aware that there was a
I 4	A. Bowel adhesion to what?		fellowship you were aware that there was a potential risk of dyspareunia with
4 5	<ul><li>A. Bowel adhesion to what?</li><li>Q. Or injuries to the bowels.</li></ul>	4	potential risk of dyspareunia with
5	Q. Or injuries to the bowels.	4 5	
	<ul><li>Q. Or injuries to the bowels.</li><li>A. It is a theoretical risk, yes.</li></ul>	4	potential risk of dyspareunia with colporrhaphies; correct?  A. Yes.
5 6	<ul><li>Q. Or injuries to the bowels.</li><li>A. It is a theoretical risk, yes.</li><li>Q. What's an ileus?</li></ul>	4 5 6	potential risk of dyspareunia with colporrhaphies; correct?
5 6 7	<ul><li>Q. Or injuries to the bowels.</li><li>A. It is a theoretical risk, yes.</li><li>Q. What's an ileus?</li></ul>	4 5 6 7	potential risk of dyspareunia with colporrhaphies; correct? A. Yes. Q. And during your fellowship you
5 6 7 8	<ul><li>Q. Or injuries to the bowels.</li><li>A. It is a theoretical risk, yes.</li><li>Q. What's an ileus?</li><li>A. Intestines that don't move,</li></ul>	4 5 6 7 8	potential risk of dyspareunia with colporrhaphies; correct? A. Yes. Q. And during your fellowship you were also aware that there was a risk of
5 6 7 8 9	<ul><li>Q. Or injuries to the bowels.</li><li>A. It is a theoretical risk, yes.</li><li>Q. What's an ileus?</li><li>A. Intestines that don't move, they're slowed.</li></ul>	4 5 6 7 8 9	potential risk of dyspareunia with colporrhaphies; correct?  A. Yes. Q. And during your fellowship you were also aware that there was a risk of dyspareunia with other prolapse surgeries;
5 6 7 8 9 10	<ul> <li>Q. Or injuries to the bowels.</li> <li>A. It is a theoretical risk, yes.</li> <li>Q. What's an ileus?</li> <li>A. Intestines that don't move,</li> <li>they're slowed.</li> <li>Q. And did you learn during your</li> </ul>	4 5 6 7 8 9 10	potential risk of dyspareunia with colporrhaphies; correct?  A. Yes. Q. And during your fellowship you were also aware that there was a risk of dyspareunia with other prolapse surgeries; correct?
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	Page 113	_	Page 114
1	with Prolift+M®?	1	your fellowship; correct?
2	A. No.	2	A. Yes.
3	Q. Did you ever undergo any of the	3	Q. And when was this in 2002 or
4	Prolift® training?	4	2003, approximately, when you switched over
5	A. No.	5	to polypropylene mesh?
6	Q. I would assume you never	6	A. In that time frame. In the time
7	underwent Prosima® training either.	7	frame from 2001 to 2003, it was in there
8	A. Correct. I have not.	8	somewhere.
9	Q. Why did you switch from Gore-Tex	9	Q. So sometime around 2001 to 2003
10	mesh to polypropylene mesh?	10	you began using polypropylene mesh in your
11	A. Because I	11	sacrocolpopexies instead of Gore-Tex mesh?
12	MR. ANDERSON: Objection.	12	A. That is correct.
13	Asked and answered.	13	Q. After 2003 what other meshes have
14	Go ahead.	14	you used during your sacrocolpopexies?
15	THE WITNESS: I was having too	15	A. It's only been the polypropylene.
16	many problems with the Gore-Tex,	16	Q. How many sacrocolpopexies have
17	specifically erosion. Extrusion. Excuse	17	you done since 2003?
18	me. Vaginal extrusion.	18	A. Roughly 150.
19	BY MR. SNELL:	19	Q. And those are sacrocolpopexies in
20	Q. And with the Gore-Tex mesh you	20	which you were the lead surgeon?
21	were having that mesh extrude into the	21	A. Yes.
22	vagina?	22	Q. Besides the AMS IntePro
23	A. Correct.	23	A. IntePro, yeah.
24	Q. And this was a potential	24	Q that you earlier identified as
25	complication that you were aware of during	25	the polypropylene mesh that you used for
	Page 115	4	Page 116
1	your sacrocolpopexies, can you tell me the	1	with that. But it wasn't like I was forced
2	other types of polypropylene meshes you've	2	to use that product. I chose to use it.
3	used for sacrocolpopexy?	3	Q. And the AMS, was it a particular
4	A. In 2002, 2003, whenever I made	4	AMS polypropylene mesh that you chose in
5	the switchover, I as the best I can	5	2002 that's different from the IntePro?
6	recall, we used an AMS product, American	6	A. They
7	Medical Systems, and then when IntePro came	7	Q. I'm not following it.
8	out, started using IntePro. And I don't	8	A. No. I understand. Because they
9	recall when that was because it was a minor	9	had a product that was used for
10	variation between the product. And so I've	10	sacrocolpopexy, I don't recall the name of
11	only used, to the best of my knowledge, only	11	it, and
12 13	used that product.	12	Q. Can I stop you right there?
14	Q. In the time period of 2003 to	13	Before you came back from your
	strike that.	14	fellowship, did they already have a mesh for
15	In the time period of 2002 to	15 16	sacrocolpopexies at Mayo?
16 17	2009 did Mayo have other manufacturers'	16 17	A. No. Q. Okay.
18	polypropylene mesh that you could choose or did they only have AMS products, for	18	
19	whatever reason?	19	A. Well, I don't recall. Nobody that I know used it. The GYN department may
20	A. No. We could choose. We chose	20	have.
21	the product that we felt was the best and	21	Q. Okay.
22	then it went to a selection committee, which	22	A. But not not anybody in my
. / ·	then looked at the pricing. And if there	/ <	nanarrmanr -
23 24	then looked at the pricing. And if there	23 24	department.
23 24 25	then looked at the pricing. And if there were another variant that was the same price or less that we agreed with, we could go	23 24 25	Q. Okay. A. So then AMS had a certain

Page 117 Page 118 And that Y is then the -- the 1 product, I don't recall the name. It was 1 2 polypropylene. I used it. And then they 2 anterior limb is then sewn to this, the 3 came out with this IntePro, which is just a 3 longer strip. So the only trimming that 4 mild variation. I think they sutured the 4 takes place is trimming the anterior and 5 5 mesh together a little differently. And I posterior arms for the length of the vagina 6 used that. It was a very subtle difference. 6 and then trimming the sacrum part. 7 Was this a mesh that you cut to 7 Q. What's the pore size on the AMS 8 8 IntePro? shape? 9 A. It was already Y-shaped. 9 A. I don't know. Actually, it's called IntePro Y-shaped mesh, 10 10 What's the pore size on the as I recall. I haven't looked at the box in 11 11 initial polypropylene mesh you began using a long time. And it was Y-shaped. You 12 12 from AMS? trimmed the limbs to fit to the patient. 13 13 A. I don't know. The first polypropylene mesh you 14 14 MR. ANDERSON: Lunch is here used for sacrocolpopexies, was that already 15 15 whenever you're ready there. Y-shaped or did you have to cut it into that MR. SNELL: All right. This is 16 16 configuration? 17 17 good. 18 A. It was Y shapes. So by Y I mean 18 MR. ANDERSON: All right. there's a long strip and another strip comes 19 19 (Luncheon recess, 20 off like this, so it's a Y like this, it's 20 12:36-1:40 p.m.) not a Y like this (indicating). Do you 21 21 AFTERNOON SESSION understand what I'm saying? As far as --22 22 BY MR. SNELL: like a quarterback, you know. 23 23 Q. Dr. Elliott, you earlier 24 Right. 24 testified that you were trained on the Q. 25 25 sacrospinous ligament fixation during your In the center. A. Page 119 Page 120 sacrospinous ligament fixation surgery fellowship; correct? 1 1 2 2 decades before your fellowship? Is that --MR. RESTAINO: Object. 3 THE WITNESS: I was shown the 3 No, it doesn't refresh my memory. 4 procedure. I was shown the procedure. I 4 Q. -- consistent or inconsistent with your memory? 5 think it would be an exaggeration to say I 5 6 was trained in it. Yeah, I was shown two 6 A. I just know it's been around a 7 7 long time. I don't know who invented it. times, two or three times. 8 8 BY MR. SNELL: Q. We can agree that the 9 Q. During your fellowship you were 9 sacrospinous ligament fixation surgery has 10 shown the sacrospinous ligament fixation 10 been around a long time; correct? 11 surgery; correct? Yes. Yes. Correct. 11 12 Yes. 12 O. And there's a potential risk of Α. urinary dysfunction with the sacrospinous 13 And you were aware from all the 13 training that you had received up to date ligament fixation surgery; correct? 14 14 15 that the sacrospinous ligament fixation 15 A. Yes. surgery to treat prolapse had been performed Q. And there is a risk of urinary 16 16 for decades by surgeons in the United States dysfunction with other prolapse surgeries; 17 17 18 prior to the time of your fellowship; right? 18 correct? Yeah. I don't know when the A. Well, I mean, other, I mean, 19 19 20 procedure was introduced. I knew it was a 20 that's -- that's broad. long-standing procedure. So I can't say 21 21 Q. It's meant to be broad. 22 decades or not. It was a preexisting 22 Well, then make it specific. 23 Q. You can answer specific if you'd surgery. 23 Q. Does it refresh your recollection like. I just would like to know whether you 24 24 25 if I say that Richter introduced the 25 would agree that urinary dysfunction is a

Page 121 Page 122 potential complication with prolapse Yes. 1 1 A. 2 surgeries other than the sacrospinous 2 And surgeons at the Mayo Clinic 3 ligament fixation; correct? 3 used transvaginal mesh to treat stress 4 That is correct. 4 urinary incontinence; correct? Α. 5 5 Were you ever trained on the A. I was the first one. Yes. 6 transvaginal placement of mesh to treat 6 Q. In fact, the majority of surgeons 7 pelvic organ prolapse? 7 at the Mayo Clinic use transvaginal mesh to 8 Transvaginal, no, I was not. 8 treat stress urinary incontinence; correct? 9 9 And during your time at the Mayo Thev --A. Clinic were you ever trained on the 10 10 MR. ANDERSON: Objection. 11 transvaginal placement of mesh for prolapse? 11 Go ahead. A. No. No one at the Mayo Clinic 12 12 THE WITNESS: They all do. uses mesh for prolapse, for transvaginal 13 13 BY MR. SNELL: pelvic organ prolapse. 14 14 Q. And at the Mayo Clinic the most Q. I'm not talking about currently. common procedure done with transvaginal mesh 15 15 I mean 2002 to let's say 2010. placement to treat stress urinary 16 16 A. Well, I thought I answered the incontinence is via the transobturator 17 17 18 question. No, I was not trained. No one at 18 route: correct? the Mayo Clinic uses transvaginal pelvic 19 19 A. I can only speak to my practice 20 organ prolapse mesh. 20 because I don't know the other practices, the breakdown, but in my practice that is a 21 Q. Ever, to your knowledge? 21 To my knowledge, ever. Yeah. 22 22 correct statement. Α. You have been trained on the 23 23 Q. And you have described the 24 transvaginal placement of mesh to treat 24 transvaginal use of mesh via the stress urinary incontinence; correct? 25 25 transobturator route to treat stress urinary Page 123 Page 124 incontinence as a minimally invasive 1 A. Well, I was familiar with the 1 2 2 other approaches already, the much more procedure, haven't you? invasive autologous, so the -- specifically 3 A. Have I -- have I used those 3 the transobturator, that would have been in 4 4 words? 5 Q. Yes. 5 2002, 2003. I took several courses with 6 6 Carl Klutke, who was at St. Louis, Rodney A. I -- I may have. I don't recall 7 an incidence, but I would not deny it or say 7 Appell, who's passed away, used to be at 8 I haven't done it. I'd have to look at the 8 Baylor, and there was somebody else that I 9 reference. 9 learned with -- oh, and actually George 10 Q. Well, you would agree that the 10 Webster, there was a female urology course use of transvaginal mesh to treat stress at some point in time that I took, talking 11 11 urinary incontinence via the transobturator with them, their feelings about it and the 12 12 route is a minimally invasive procedure; technique, and then watching surgical videos 13 13 14 correct? 14 too. 15 A. Has to be what you're comparing 15 Where were those surgical videos Q. it to. If you're comparing it to the from? 16 16 traditional autologous sling, by all means. 17 17 A. They were provided by Coloplast. 18 If you're comparing it to DEFLUX injection 18 Actually, at the time they were provided by for stress urinary incontinence, then it is Mentor Corporation. 19 19 20 much more invasive. So "minimally invasive" 20 Q. And you used polypropylene mesh is a relative term. There is not a during your stress urinary incontinence 21 21 surgeries performed via the transobturator 22 definition of that. 22 Q. And who trained you on the approach; correct? 23 23 24 transobturator placement of slings to treat 24 A. Yeah, that's what I use now. 25 stress urinary incontinence? 25 Yes.

		Page 125			Page 126
1	Q. The traditional pubovaginal		1	slings include cadaveric slings; correct?	
2	slings, that would include the autologous		2	A. Uh-huh. Yes.	
3	slings that you referenced a few minutes		3	Q. As well as autologous, as you	
4	ago; correct?		4	earlier testified; correct?	
5	A. Correct.		5	A. Yes.	
6	Q. And you would agree that compared		6	Q. The autologous is the patient's	
			7		
7	to these autologous slings, the			own tissue; correct?	
8	transobturator placement of polypropylene		8	A. Yes.	
9	mesh to treat stress urinary incontinence is		9	Q. And that tissue has to be	
10	less invasive; correct?		10	harvested from the patient; correct?	
11	A. I would agree. Comparing it as		11	A. Yes.	
12	you just so we're clear, comparing it		12	Q. The harvesting of tissue from a	
13	next to autologous slings, yes, it would be		13	patient for any type of sling material	
14	less invasive.		14	increases morbidity; correct?	
15	Q. Autologous slings to treat stress		15	A. Yes.	
16	urinary incontinence are more invasive than		16	Q. And, in fact, for the	
17	the transobturator slings; correct?		17	sacrocolpopexy, surgeons sometimes use	
18	A. Yes.		18	rectus fascia harvested and then that will	
19	Q. And you have said that the		19	be used to attach the vagina to the sacrum;	
20	traditional pubovaginal slings are rarely		20	correct?	
21	done nowadays because of the minimally		21		
				MR. ANDERSON: Objection.	
22	invasive outpatient approaches with the		22	Go ahead.	
23	transobturator approach.		23	THE WITNESS: I'm not familiar	
24	A. Correct.		24	with anybody doing that anymore because	
25	Q. The traditional pubovaginal		25	there have been studies by Brubaker, et al.,	
		Page 127			Page 128
1	and others showing that autologous fascia		1	long term; correct?	
2	does not work well for it, and that's why		2	A. No. It's a feasible option long	
3	the transition over to synthetics. Some		3	term.	
4	individuals may be doing it but there are		4	Q. I'm sorry?	
5	some very good data against it.			A 711 C 111 11 1	
6			5	<ul> <li>A. It's a feasible option long term.</li> </ul>	
	BY MR. SNELL:		6	•	
7				Q. Well, what's the data you	
7	Q. There are very good data against		6 7	Q. Well, what's the data you referred to by Brubaker, et al.?	
7 8	Q. There are very good data against the use of pubovaginal strike that.		6 7 8	Q. Well, what's the data you referred to by Brubaker, et al.? A. That the failure rate was high.	
7 8 9	Q. There are very good data against the use of pubovaginal strike that.  There are good data against the		6 7 8 9	Q. Well, what's the data you referred to by Brubaker, et al.? A. That the failure rate was high. Brubaker might have been the	
7 8 9 10	Q. There are very good data against the use of pubovaginal strike that.  There are good data against the use of autologous tissues for the treatment		6 7 8 9 10	Q. Well, what's the data you referred to by Brubaker, et al.? A. That the failure rate was high. Brubaker might have been the lead author. I can't say it was actually	
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	Page 129		Page 130
1	the Mentor sling for stress urinary	1	Q. So
2	incontinence? And what I'm talking about is	2	A. In that time frame.
3	specifically that sling as opposed to some	3	Q. Until when?
4	other manufacturer of sling.	4	A. Well, when I got the 100 cases.
5	A. That was the transobturator sling	5	I do about roughly 80 to 150 cases a year.
6	specifically. Because I was already using	6	There's wide variation in my practice. And
7	the suprapubic, the SPARC, by AMS. Okay?	7	so however long it took me to do 100 cases.
8	So in 2002, 2003 the	8	Q. And after using the OB Tape did
9	transobturator was introduced to the United	9	you switch to a different type of
10	States. It had been in Europe prior to that	10	polypropylene mesh to treat stress urinary
11	time. So I was aware of it. Mentor	11	incontinence?
12	Corporation, as I I believe was the first	12	A. Yes. We went to well, no. I
13	one to be able to offer it in the United	13	continued using the SPARC and then but
14	States. At least I was I was contacted.	14	
		15	that's suprapubic. And so then
15	So they came to me saying, hey, we have our		transobturator, then I started using the
16	transobturator sling here. It was the OB	16	Monarc by AMS.
17	Tape.	17	Q. So TVT-O was OB Tape, then
18	Q. And for how long did you use the	18	A. Well, TVT-O was a product. I
19	OB Tape?	19	don't use TVT-O.
20	A. 100 cases.	20	Q. The transobturator polypropylene
21	Q. What years?	21	meshes you've used have been OB Tape and
22	A. Oh, I don't know. 2000	22	then
23	actually, I I just don't know. It was	23	A. Monarc.
24	when it was introduced, 2003, 2004, '5,	24	Q Monarc.
25	something like that.	25	A. Yeah. M-O-N-A-R-C.
,	Page 131	4	Page 132
1	Q. And the suprapubic sling that you		
l o	used was CDADC	1	approach with the polypropylene sling. Is
2	used was SPARC.	2	that correct or am I misstating?
3	A. SPARC. And it stands for	2 3	that correct or am I misstating?  A. To be correct, no question, I was
3 4	A. SPARC. And it stands for suprapubic ARC. And that's by AMS.	2 3 4	that correct or am I misstating?  A. To be correct, no question, I was the first to use suprapubic
3 4 5	A. SPARC. And it stands for suprapubic ARC. And that's by AMS. Q. Have you used any other type of	2 3 4 5	that correct or am I misstating?  A. To be correct, no question, I was the first to use suprapubic Q. Okay.
3 4 5 6	<ul><li>A. SPARC. And it stands for suprapubic ARC. And that's by AMS.</li><li>Q. Have you used any other type of</li><li>is that also called the retropubic</li></ul>	2 3 4 5 6	that correct or am I misstating?  A. To be correct, no question, I was the first to use suprapubic Q. Okay. A and transobturator, and I most
3 4 5 6 7	<ul><li>A. SPARC. And it stands for suprapubic ARC. And that's by AMS.</li><li>Q. Have you used any other type of is that also called the retropubic approach by some?</li></ul>	2 3 4 5 6 7	that correct or am I misstating?  A. To be correct, no question, I was the first to use suprapubic Q. Okay.  A and transobturator, and I most likely was the first in the state of
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١,	Page 133	4	Page 134
1	that.	1	on that. You look at OB Tape, hold it up to
2	BY MR. SNELL:	2 3	the light, there are essentially no pores in
3	Q. Do you know the thickness in millimeters of that mesh?		it. It's a thick band. Looks like a piece
4		4 5	of ribbon, almost. So I can't answer your
5 6	A. No. Q. Do you know the flexural rigidity	6	question; however, I can theorize it's tiny and go ahead.
7	of that mesh?	7	Q. I didn't mean to interrupt you.
8	A. Flex?	8	Go ahead.
9	MR. ANDERSON: Objection.	9	A. No. No.
10	BY MR. SNELL:	10	Q. I thought you were done. I
11	Q. Flexural rigidity.	11	apologize.
12	A. Flexural rigidity? Do you have a	12	A. I'm sorry.
13	math equation for that one? Maybe I'll	13	Q. Do you know the density of the OB
14	figure it out. Flexural rigidity, because	14	Tape mesh?
15	that's a math we can figure that on a	15	A. No, I do not.
16	math equation.	16	Q. Well, what about the thickness of
17	Q. As you sit here, do you know it?	17	it; do you know that, by chance?
18	A. No. That's why I was asking. So	18	A. No, I do not.
19	the answer then would be no.	19	Q. The mesh used in the Monarc
20	Q. For the OB Tape mesh that you	20	transobturator, that's a polypropylene mesh;
21	used beginning around 2002, do you know what	21	correct?
22	the pore size was for that?	22	A. It's the same mesh as SPARC.
23	A. That is a very interesting	23	Q. So the same answers would hold
24	question because with OB Tape I am not a	24	true, then. You don't know what the pore
25	materials expert so I have to be very clear	25	size is of that mesh.
	5 405		
1	A. Correct.	1	Page 136 their product brochures, reviewed lectures
1 2	Q. Or the density or thickness;	2	provided to me by outside their
3	correct?	3	clinicians, but no independent research, no.
4	A. Correct.	4	Q. Have you ever used Vipro to treat
5	Q. When was the last time you used	5	pelvic organ prolapse?
6	polypropylene mesh to treat stress urinary	6	A. Vipro. I'm not no.
7	incontinence?	7	Q. Do you know what Vipro is?
8	A. Last week.	8	A. I believe it's a Vicryl-related
9	Q. You earlier testified that you	9	absorbable type of mesh.
10	switched from using Gore-Tex mesh to	10	Q. Since you've been at Mayo Clinic,
11	polypropylene mesh.	11	is it correct that the only meshes you have
12	Why did you make that switch	12	used since switching from Gore-Tex are
13	A. Because	13	polypropylene-based meshes for the treatment
14	Q specific to polypropylene?	14	of prolapse?
15	A. Why did I switch to	15	A. I don't know what OB Tape was
16	polypropylene?	16	made of so
17	Q. Yes.	17	Q. I thought I thought OB Tape
18	A. Because that was the product that	18	was urinary incontinence.
19	the AMS company came to me with.	19	A. It is. Did you say meshes?
20	المناطنة المستواد المستود المستود المستود المستود المستود المستود المستود المستود المستود المستود المستود المستود المستو		MR. ANDERSON: He said
	Q. So you didn't do any individual	20	
21	scientific analysis of materials that were	21	MR. SNELL: Here. Let me give
21 22	scientific analysis of materials that were available	21 22	MR. SNELL: Here. Let me give it.
21 22 23	scientific analysis of materials that were available A. I	21 22 23	MR. SNELL: Here. Let me give it. BY MR. SNELL:
21 22	scientific analysis of materials that were available	21 22	MR. SNELL: Here. Let me give it.

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	Page 137		Page 138
1	used since switching from Gore-Tex are	1	not I don't understand it. I understand it.
2	polypropylene-based meshes I see where	2	I said it's morbid.
3	you're going. Okay. I should have put that	3	Q. And it's morbid because they
4	in the beginning.	4	create an incision, they tunnel under the
5	For the treatment of	5	skin, use something like a Lausanne stripper
6	prolapse	6	to strip out the flesh to be used as an
7	A. Okay. Yeah.	7	autologous sling; correct?
8	Q since switching from Gore-Tex	8	A. Yes.
9	mesh, are the only meshes that you have been	9	Q. And, in your mind, that's a very
10	using the polypropylene-based meshes?	10	morbid procedure; correct?
11	A. Yes.	11	A. Yeah. Yes. Correct.
12	Q. Besides harvesting flesh from the	12	Q. And that's why you don't do
13	rectus fascia, surgeons also harvested flesh	13	autologous sling placements; correct?
14	from patients, from their fasciae latae, to	14	A. I still will do autologous
15	have an autologous band of tissue; correct?	15	slings. They're rare. There's unique
16	A. Yes.	16	circumstances I will do it. I will not
17	Q. When is the last time you did	17	harvest from the fasciae latae, though.
18	that to a patient?	18	Q. You will use cadaveric?
19	A. Never.	19	A. No. Autologous is autologous.
20		20	Cadaveric is cadaveric.
21	= *	21	
22	•	22	Q. I'm sorry. Where would you harvest from?
23	Q. What they do is they create an incision for the fasciae latae		
		23	A. The rectus.
24	A. No. I know how to do the	24	Q. Rectus fascia?
25	procedure. That's not the my answer was	25	A. Correct.
	Page 139		Page 140
1	Q. And even when you harvest from	1	Page 140 A. I suspect it probably has.
2	the rectus fascia, you tell patients that	2	Q. When you say theoretical, what do
	there can be additional complications or	_	
1 7			
3		3	you mean by that term?
4	morbidity from that harvesting alone and	3 4	you mean by that term?  A. Well, the rectum is actually
4 5	morbidity from that harvesting alone and apart from the procedure in which you're	3 4 5	you mean by that term? A. Well, the rectum is actually quite a ways away from the vagina when
4 5 6	morbidity from that harvesting alone and apart from the procedure in which you're going to use that tissue; right?	3 4 5 6	you mean by that term?  A. Well, the rectum is actually quite a ways away from the vagina when you're doing your dissection. It is it's
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4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	morbidity from that harvesting alone and apart from the procedure in which you're going to use that tissue; right?  A. Correct. Q. In the last 1990s, the POPQ scale was adopted by the International Incontinence Society; correct?  A. Yes. Q. And that brought with it a standardized way of measuring prolapse for the first time.  A. Correct. Q. And since that time surgeons in clinical studies have used the POPQ scale to assess prolapse; correct?  A. Some have, yes. Q. Sacrocolpopexy, does it have a risk of rectal injury?  A. Theoretically, yes. Q. Has rectal injury been reported in any clinical studies that you're aware of	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	you mean by that term?  A. Well, the rectum is actually quite a ways away from the vagina when you're doing your dissection. It is it's not close. The bladder is close and adherent but the rectum is a long ways away, unless they've had some type of previous operations and it will be scarred in. So yes, theoretically, it is a risk.  Q. Okay. I understand.  A. But Q. Injury to the bladder is a risk with sacrocolpopexy.  A. Yes.  Q. And that's because of the proximity of the bladder to the planes in the dissection areas for the sacrocolpopexy; correct?  A. Yes. And frequently, that there's previous scar tissue there from previous surgeries. So it's much more stuck.
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Page 141 Page 142 to the great vessels when you do a No. It's because you've cut into 1 1 2 sacrocolpopexy; correct? 2 veins that are the presacral veins. So it 3 MR. ANDERSON: Objection. 3 has nothing necessarily to do with the mesh 4 THE WITNESS: Again, that falls 4 itself. It's your dissection. 5 5 in line with theoretically. The great Q. So part of the risk with 6 vessels aren't really where you're working. 6 dissection in a sacrocolpopexy is the risk 7 We have a good amount of distance away from 7 to cutting into the presacral veins. 8 8 them. Yes. 9 9 BY MR. SNELL: Osteomyelitis has been described Q. 10 Q. Is there a risk of injury to the 10 as a complication associated with 11 internal iliac vessel with sacrocolpopexy? 11 sacrocolpopexy; correct? Yes, there's going to be a 12 12 Yes. A. potential risk. Yes. That risk should be Sacral bone infection --13 13 Q. very uncommon and remote. 14 14 Α. What's a presacral hemorrhage? 15 Q. 15 Q. -- is a risk with sacrocolpopexy? Presacral is from the presacral 16 16 A. vessels on the sacrum itself. So the veins 17 17 The abdominal sacrocolpopexy is a O. 18 bleed. 18 procedure that can take over three hours; 19 Q. So there's a risk of presacral 19 correct? 20 hemorrhage with sacrocolpopexy? 20 MR. ANDERSON: Objection. A. Yes. That's been very well 21 21 Go ahead. 22 22 THE WITNESS: I can only answer described. for myself. And it shouldn't. You should 23 Q. And that's because you're 23 attaching part of that mesh up to the 24 24 be out of there in two hours. 25 25 sacrum; correct? BY MR. SNELL: Page 143 Page 144 Q. You never had cases where it's 1 on it but... 1 2 2 taken you more than three hours to perform a Q. What's your recollection of your sacrocolpopexy? An open abdominal first case of robotic sacrocolpopexy? 3 3 4 sacrocolpopexy. 4 A. I was thinking it was in 2002, 5 A. Yeah, open abdominal. 5 but I don't -- it was in that time frame. 6 I may have. I mean, it's 6 O. Your first case of robotic 7 within the realm of possibility, but it --7 sacrocolpopexy took you about four hours and 8 but it should move along. 8 45 minutes long. 9 Q. One of the reasons why you began 9 Do you recall ever saying that? 10 performing robotic laparoscopic 10 Correct. Yeah. sacrocolpopexies is because of the high Q. When you first began doing the 11 11 degree of morbidity associated with an open robotic laparoscopic sacrocolpopexy to treat 12 12 abdominal sacrocolpopexy; isn't that prolapse, did you use the da Vinci machine? 13 13 14 Yes. correct? 14 A. 15 A. Higher degree of morbidity. 15 Q. Robot? There's a difference to me. That's the only robot 16 16 Q. Were you performing laparoscopic commercially available that I'm familiar 17 17 with. 18 sacrocolpopexy before you began doing 18 robotic laparoscopic sacrocolpopexy? So in your first case of robotic 19 19 20 20 sacrocolpopexy in either 2001 or 2002, that A. No. was done with the da Vinci robot. 21 Q. Your first case of robotic 21 22 laparoscopic sacrocolpopexy was in 2001; 22 A. Correct. Q. And all of your subsequent cases 23 correct? 23 A. I'd have to look at the date on of robotic laparoscopic sacrocolpopexy to 24 24 25 it. I don't recall the manuscript out there 25 treat vaginal prolapse have been with the da

	Page 145		Page 146
1	Vinci robot?	1	Cleveland Clinic in urology and fellowship
2	A. Correct.	2	at Hopkins. And his fellowship is
3	Q. And how were you trained on the	3	specifically robotics. Well,
4	da Vinci robot?	4	robotics/laparoscopy. It's a combined
5	A. I am not. Dr. Chow, my partner,	5	fellowship.
6	is. As I mentioned earlier, this is a team.	6	Q. When you switched from the
7	We do this.	7	Gore-Tex mesh to the polypropylene mesh for
8	Q. How do you Dr. Chow?	8	your sacrocolpopexies, is it correct that
9	A. Dr. Chow, C-H-O-W. George Chow.	9	you thereafter continued to do open
10	Q. So when you would do a robotic	10	abdominal sacrocolpopexies?
11	laparoscopic sacrocolpopexy, it would be you	11	A. Yes. I I changed from
12	and Dr. George Chow performing the procedure	12	Gore-Tex to polypropylene prior to us doing
13	on a patient for prolapse treatment?	13	it robotically.
14	A. Correct.	14	Q. So when was the last time you
15	Q. Do you operate the robot?	15	performed an open abdominal sacrocolpopexy?
16	A. He drives the robot, as we say.	16	A. Probably within the last month.
17	He droves the robot. I'm the one actually	17	Q. Okay.
18	with the patient directing where Chow	18	A. More or less.
19	where dissection goes, sutures go. He is	19	Q. Since 2002, what prolapse
20	trained in, fellowship trained in robotics,	20	surgeries have you done besides open
21	and so we do that's why we do it as a	21	abdominal sacrocolpopexy and the robotic
22	team.	22	laparoscopic sacrocolpopexy which was done
23	Q. So Dr. Chow is is he	23	with you and Dr. Chow?
24	fellowship trained in robotics?	24	A. Uh-huh. The anterior
25	A. Yes. He did his residency at	25	colporrhaphy, posterior colporrhaphy, Mayo
	Page 147		Dage 140
1	Page 147	1	Page 148
1	culdoplasty.	1 2	Q. There's a higher risk to the
2	culdoplasty. Q. What's the Mayo culdoplasty? How	2	Q. There's a higher risk to the patient the longer she is under general
2 3	culdoplasty. Q. What's the Mayo culdoplasty? How is it different from the McCall's?	2 3	Q. There's a higher risk to the patient the longer she is under general anesthesia; correct?
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		I	
	Page 149		Page 15
1	that the longer you sleep, the more	1	routinely around two hours, 2:15. I'm not
2	complications.	2	denying it may have taken five hours. I
3	Q. Is that something that you	3	just don't recall.
4	disagree with?	4	Q. When you first began using
5	A. No. I agree with it.	5	Gore-Tex during your fellowship for the
6	Q. Okay.	6	sacrocolpopexies, did you investigate
7	A. I have not studied it myself.	7	whether the FDA had cleared it for the
8	Q. And the ileus you identified as	8	treatment of pelvic organ prolapse?
9	what we earlier discussed, the intestinal	9	MR. ANDERSON: Objection.
10	blockage?	10	Asked and answered.
11	A. Not blockage. Slowed down.	11	Go ahead.
12		12	
	There is no blockage. There's a huge		THE WITNESS: No, I I
13	difference. It's just that the intestines	13	assumed the company had done that. I
14	are somewhat stunned after anesthesia. They	14	trusted their opinion, if they're providing
15	take a while to wake up.	15	it for me, that it had been approved.
16	Q. In your robotic laparoscopic	16	BY MR. SNELL:
17	sacrocolpopexy cases, some of them have	17	Q. When you first began using the
18	taken up to five hours to complete; correct?	18	Gore-Tex mesh strike that.
19	A. I'd have to review our data on	19	During your use of the Gore-Tex
20	it. I don't recall.	20	mesh in your fellowship to treat
21	Q. As you sit here, you don't	21	sacrocolpopexy, did you read the IFU to
22	recall?	22	check the indications of use?
23	A. I don't no. I have a paper	23	A. The IFU that was yes. The IFU
24	out, our first 30. I'd have to look at	24	that was provided for us, this was a sheet
25	that. But now we're up to 90. So now we're	25	of Gore-Tex, I don't remember how large, but
25	that. But now were up to 30. 30 now were	23	or dore rex, I don't remember now large, but
	Page 151		Page 15
1	it was like let's just say eight by eight or	1	Sacrocolpopexy for Severe Vaginal Vault
2	something like that. It was a sheet. And	2	Prolapse: Indications and Results,"
3	then the surgeon would cut it out to form	3	published in "Issues In Incontinence," 2000.
4	whatever shape he needed. And so I do	4	Number 1 on the non-peer reviewed.
5	remember he gave it to me, I reviewed it	5	BY MR. SNELL:
6	because I was writing up a paper at the		
7	because I was writing up a paper at the		O Turn if you would to Page 4 of
/	time which is in my CV about	6	Q. Turn, if you would, to Page 4 of
0	time, which is in my CV, about	7	your CV.
8	sacrocolpopexy.	7 8	your CV. A. Okay.
9	sacrocolpopexy. Q. Okay.	7 8 9	your CV. A. Okay. Q. Under "Presentations,
9 10	sacrocolpopexy. Q. Okay. A. Because I rely on those.	7 8 9 10	your CV. A. Okay. Q. Under "Presentations, International," it says,
9 10 11	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific	7 8 9 10 11	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France,"
9 10 11 12	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was?	7 8 9 10 11 12	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004.
9 10 11 12 13	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it	7 8 9 10 11 12 13	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that?
9 10 11 12 13 14	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the	7 8 9 10 11 12 13 14	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes.
9 10 11 12 13 14 15	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it	7 8 9 10 11 12 13	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that?
9 10 11 12 13 14	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the	7 8 9 10 11 12 13 14	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes.
9 10 11 12 13 14 15	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript.	7 8 9 10 11 12 13 14 15	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in
9 10 11 12 13 14 15 16	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here.	7 8 9 10 11 12 13 14 15 16	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes.
9 10 11 12 13 14 15 16 17 18	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about,	7 8 9 10 11 12 13 14 15 16 17 18	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the
9 10 11 12 13 14 15 16 17 18	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about, Doctor?	7 8 9 10 11 12 13 14 15 16 17 18 19	your CV.  A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the presentations there concerning transvaginal
9 10 11 12 13 14 15 16 17 18 19 20	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about, Doctor? A. That's what I'm getting to.	7 8 9 10 11 12 13 14 15 16 17 18 19 20	your CV.  A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the presentations there concerning transvaginal mesh?
9 10 11 12 13 14 15 16 17 18 19 20 21	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about, Doctor? A. That's what I'm getting to. MR. ANDERSON: He's looking.	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	your CV.  A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the presentations there concerning transvaginal mesh? A. Not that I recall, no.
9 10 11 12 13 14 15 16 17 18 19 20 21 22	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about, Doctor? A. That's what I'm getting to. MR. ANDERSON: He's looking. THE WITNESS: Here we go.	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	your CV. A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the presentations there concerning transvaginal mesh? A. Not that I recall, no. Q. Did you make any presentations at
9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about, Doctor? A. That's what I'm getting to. MR. ANDERSON: He's looking. THE WITNESS: Here we go. Under "Non-peer-reviewed Articles," Elliott	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	your CV.  A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the presentations there concerning transvaginal mesh? A. Not that I recall, no. Q. Did you make any presentations at ICS/IUGA 2004?
9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about, Doctor? A. That's what I'm getting to. MR. ANDERSON: He's looking. THE WITNESS: Here we go. Under "Non-peer-reviewed Articles," Elliott Cone, Boone. Mark Cone, that was the name	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	your CV.  A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the presentations there concerning transvaginal mesh? A. Not that I recall, no. Q. Did you make any presentations at ICS/IUGA 2004? A. Yes.
9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	sacrocolpopexy. Q. Okay. A. Because I rely on those. Q. Do you recall what specific Gore-Tex product that was? A. No. I would be able to track it down on my CV, if I could get ahold of the original manuscript. Q. I have a copy of your CV here. A. Uh-huh. 2004. Q. What paper are we talking about, Doctor? A. That's what I'm getting to. MR. ANDERSON: He's looking. THE WITNESS: Here we go. Under "Non-peer-reviewed Articles," Elliott	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	your CV.  A. Okay. Q. Under "Presentations, International," it says, "Colloquium-ICS/IUGA, 2004, Paris, France," August 2004. Do you see that? A. Yes. Q. Did you attend ICS/IUGA 2004 in Paris, France? A. Yes. Q. Did you see any of the presentations there concerning transvaginal mesh? A. Not that I recall, no. Q. Did you make any presentations at ICS/IUGA 2004?

1 A. I don't know. It doesn't state 2 it there. For some reason, it's not on the 3 CV. 4 Q. It's not listed anywhere in your 5 CV what presentation you made at ICS/IUGA 6 2004? 7 A. No. It was a poster. I know 8 that. 9 Q. What was it a poster about? 10 A. That's what I don't know. I know 11 I had that poster because I had to carry it 12 all the way from Minneapolis to Paris, but I 13 don't remember what the subject matter was. 14 Q. As you sit here today, you don't 15 know whether it was prolapse, urinary 16 incontinence or some other condition that 17 you treated back then at that time? 18 A. It would have been one of those 19 there any randomized, controlled trials of that procedure? 4 A. We were the first in the world to do it so it was impossible to have that. 9 Q. So when you began performing robotic laparoscopic sacrocolpopexies, there were no randomized, controlled trials on that procedure anywhere in the world; correct? 11 A. That I am familiar with, correct. Yes. 12 Q. When was the first randomized, controlled clinical trial involving robotic laparoscopic sacrocolpopexy published? 16 A. I'm not familiar. I don't know. 17 you treated back then at that time? 18 A. It would have been one of those 19 two because it's essentially a female 20 urology or voiding dysfunction. 20 Know. I'd have to do a literature search.	154
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6 Q. So when you began performing 7 A. No. It was a poster. I know 8 that. 8 were no randomized, controlled trials on 9 Q. What was it a poster about? 9 that procedure anywhere in the world; 10 A. That's what I don't know. I know 11 I had that poster because I had to carry it 12 all the way from Minneapolis to Paris, but I 13 don't remember what the subject matter was. 14 Q. As you sit here today, you don't 15 know whether it was prolapse, urinary 16 incontinence or some other condition that 17 you treated back then at that time? 18 A. It would have been one of those 19 two because it's essentially a female  6 Q. So when you began performing 7 robotic laparoscopic sacrocolpopexies, there 8 were no randomized, controlled trials on 9 that procedure anywhere in the world; 10 correct? 11 A. That I am familiar with, 12 correct. Yes. 13 Q. When was the first randomized, 14 controlled clinical trial involving robotic 15 laparoscopic sacrocolpopexy published? 16 A. I'm not familiar. I don't know. 17 Q. You don't even know of one that's 18 ever been published; correct? 19 two because it's essentially a female	
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19 two because it's essentially a female 19 A. There may have been. I don't	
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170 HEOLOGY OF VOIGING GYSTINGTON 170 KNOW 17 NAVE IN AN A MERALURE SEARCH	
Q. Was it a poster in connection  21 Q. You've never been involved in a	
22 with any consulting you were doing at the 22 randomized, controlled trial involving the 23 time? 23 robotic laparoscopic sacrocolpopexy;	
24 A. No. 24 correct? 25 Q. When you first began performing 25 A. Correct.	
25 Q. Which you hist began performing 25 A. correct.	
Page 155	156
1 Q. And since 2001, how many 1 That's less than ten a year;	130
2 laparoscopic strike that. 2 correct?	
3 Since 2001, how many robotic 3 A. Correct.	
4 God, I can't talk. 4 MR. SNELL: Let's mark this as	
5 MR. ANDERSON: Great 5 the next exhibit.	
6 commercial. 6 (Exhibit Elliott-3 was marked	
7 BY MR. SNELL: 7 for identification.)	
8 Q. Since 2001, how many robotic 8 BY MR. SNELL:	
9 laparoscopic sacrocolpopexies have you done? 9 Q. Doctor, I've handed you Exhibit	
10 A. 90. 10 Number 3.	
11 Q. Let's just finish up with the CV 11 Do you recognize this as one of	
12 real quick. 12 the articles that you published on	
The 2000 "Issues in 13 robotic-assisted laparoscopic sacrocolpopexy	
14 Incontinence" 14 for the treatment of vaginal vault prolapse?	
15 A. Uh-huh. 15 A. Correct.	
16 Q non-peer-reviewed article that 16 Q. This was an article published in	
17 you identified 17 2004; correct?	
18 A. Yes. 18 A. By the copyright date, that's	
19 Q is that something you have 19 what it says, yes.	
20 with you on a computer or anywhere that's 20 Q. And was this one of the	
21 convenient or is that back at your office or 21 publications you earlier referenced in your	
22 what? 22 deposition with regard to some of the early	
A. I don't have any copies, period.  23 robotic laparoscopic sacrocolpopexy cases	
24 Q. So you've performed 90 robotic 24 you had performed? 25 laparoscopic sacrocolpopexies since 2001. 25 A. I was referring to the one with	
23 Iaparoscopic sacrocorpopexies since 2001.   23 A. 1 was reletting to the one with	

	Page 157		Page 158
1	30 patients. This is one this is our	1	trocars; correct?
2	five first five. It was a feasibility	2	A. Yes.
3	study. That's why it's in "Surgical	3	Q. What's the largest size trocar
4	Techniques in Urology."	4	used during this robotic laparoscopic
5	Q. Over on the right-hand column in	5	sacrocolpopexy?
6	the paragraph that begins with	6	A. Currently, I don't know because
7	"Realizing" are you with me there?	7	they've decreased in size.
8	A. Yes.	8	Q. Back then it would have been 12
9	Q. You say, "The difficulties in	9	millimeters
10	performing the procedure and the duration of	10	A. That
11	the operation has, however, limited its	11	Q to place the camera port?
12	use."	12	A. That's correct.
13	You're referring to the	13	Q. There would be a 10-millimeter
14	laparoscopic sacrocolpopexy there?	14	trocar; correct?
15	A. That's what it states, yes.	15	A. Yes.
16	Q. Turn to the next page, Figure 1.	16	<ul><li>Q. A couple 8-millimeter trocars;</li></ul>
17	This is a picture of the different ports and	17	correct?
18	strike that.	18	A. Yes.
19	Figure 1 is a picture of the	19	Q. A 5-millimeter trocar port one
20	different port placements associated with	20	hand breadth inferior laterally?
21	the da Vinci robotic laparoscopic	21	A. Yeah, that's what it states.
22	sacrocolpopexy that you were performing?	22	Yes.
23	A. Correct.	23	Q. A little below that you note that
24	Q. And for the robotic laparoscopic	24	the two 8-millimeter robotic ports are
25	sacrocolpopexy, that involves the use of	25	placed lateral to the rectus; correct?
	Page 1E0		Page 160
1	Page 159	1	Page 160
1 2	A. Well, it states, 8-millimeter	1 2	Q. In your first description of your
2	A. Well, it states, 8-millimeter robotic ports placed at inferior lateral	2	Q. In your first description of your use of the da Vinci robot to do prolapse
2	A. Well, it states, 8-millimeter robotic ports placed at inferior lateral rectus. So that's	2	Q. In your first description of your use of the da Vinci robot to do prolapse surgery you described the distance in finger
2 3 4	A. Well, it states, 8-millimeter robotic ports placed at inferior lateral rectus. So that's Q. I'm sorry. We must be at the	2 3 4	Q. In your first description of your use of the da Vinci robot to do prolapse surgery you described the distance in finger breadths.
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2 3 4 5 6 7	A. Well, it states, 8-millimeter robotic ports placed at inferior lateral rectus. So that's Q. I'm sorry. We must be at the wrong A. I'm still on Figure 1. Q. Okay.	2 3 4 5 6 7	Q. In your first description of your use of the da Vinci robot to do prolapse surgery you described the distance in finger breadths.  A. Correct. Q. Figure 3 is a says, "Silastic Y-graft"; correct?
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Well, it states, 8-millimeter robotic ports placed at inferior lateral rectus. So that's Q. I'm sorry. We must be at the wrong A. I'm still on Figure 1. Q. Okay. A. That's what it describes there. Q. I'm in the text now at the bottom of Page 374, the last sentence in the first column. A. Yeah. Two 8-millimeter robotic ports are placed lateral to the rectus two finger breadths superior to the iliac crest. Q. And when you use the term "two finger breadths," that's a term that's been used in your medical training; correct?  MR. ANDERSON: Objection. Go ahead. THE WITNESS: Well, two finger breadths is just a a rough estimate. In subsequent papers we actually use	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. In your first description of your use of the da Vinci robot to do prolapse surgery you described the distance in finger breadths.  A. Correct. Q. Figure 3 is a says, "Silastic Y-graft"; correct? A. Yes. Q. Is this the AMS graft that you earlier identified or is this the Gore-Tex graft?  A. No, this is not this is the one in between the Gore-Tex and then the AMS polypropylene. And then it says here, "Silastic Y-graft." We used this only a very short period of time. Q. So tell me about this Silastic Y graft. What kind of graft is that? A. I well, it says, "Silastic Y-graft." That's about all I know because I don't I don't recall. Usually in the manuscripts we put in who makes it and
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Well, it states, 8-millimeter robotic ports placed at inferior lateral rectus. So that's Q. I'm sorry. We must be at the wrong A. I'm still on Figure 1. Q. Okay. A. That's what it describes there. Q. I'm in the text now at the bottom of Page 374, the last sentence in the first column. A. Yeah. Two 8-millimeter robotic ports are placed lateral to the rectus two finger breadths superior to the iliac crest. Q. And when you use the term "two finger breadths," that's a term that's been used in your medical training; correct? MR. ANDERSON: Objection. Go ahead. THE WITNESS: Well, two finger breadths is just a a rough estimate. In subsequent papers we actually use centimeters. But in here it does say two	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. In your first description of your use of the da Vinci robot to do prolapse surgery you described the distance in finger breadths.  A. Correct. Q. Figure 3 is a says, "Silastic Y-graft"; correct? A. Yes. Q. Is this the AMS graft that you earlier identified or is this the Gore-Tex graft?  A. No, this is not this is the one in between the Gore-Tex and then the AMS polypropylene. And then it says here, "Silastic Y-graft." We used this only a very short period of time. Q. So tell me about this Silastic Y graft. What kind of graft is that? A. I well, it says, "Silastic Y-graft." That's about all I know because I don't I don't recall. Usually in the manuscripts we put in who makes it and things. We didn't do it in this.

	Page 161		Page 162
1	any indication of a manufacturer.	1	Q. I'm not asking what you assumed.
2	Q. Well, what's your understanding	2	I'm asking if you know.
3	of what type of material a Silastic graft	3	Do you know, Doctor, whether
4	is?	4	the Silastic grafts you used in patients in
5	A. Well, Silastic is Silastic. I	5	your first robotic sacrocolpopexy series
6	don't I don't know anything else beyond	6	were FDA-cleared for the treatment of pelvic
7	that.	7	organ prolapse?
8	Q. Is it mono-filament,	8	A. I'm going to trust the company
9	multi-filament?	9	and say yes, it is.
10	A. I don't know.	10	Q. What's the name of this company?
11	Q. Is it macro-porous or	11	A. That's what I don't know.
12	micro-porous?	12	Q. I'm not asking you to trust the
13	MR. ANDERSON: Objection.	13	company. I want to know, when you were
14	THE WITNESS: Yeah. I'm not a	14	placing this Silastic graft in patients in
15		15	
	biomaterials expert, and I'd have to look at		this sacrocolpopexy series, was that
16	it and measure it and things.	16	specific material FDA-cleared for the use of
17	BY MR. SNELL:	17	prolapse?
18	Q. Is it a synthetic material?	18	MR. ANDERSON: Objection.
19	A. Yes.	19	Asked and answered a couple different times.
20	Q. The Silastic grafts that you were	20	MR. SNELL: I'm not asking what
21	using for prolapse, do you know if they were	21	he suspects about a company. I'm saying,
22	FDA approved for the treatment of prolapse?	22	what did you know?
23	A. Well, since it was provided to me	23	MR. ANDERSON: I
24	by a company, I don't know what, I'm going	24	BY MR. SNELL:
25	to assume it is.	25	Q. Did you know whether it was or
	D 163		D 164
1	Page 163	1	Page 164
1	not?	1	minutes; correct?
2	not? MR. ANDERSON: Objection. Same	2	minutes; correct? A. Yes.
2 3	not? MR. ANDERSON: Objection. Same objection. Asked and answered.	2	minutes; correct? A. Yes. Q. With a median of 3 hours, 30
2 3 4	not? MR. ANDERSON: Objection. Same objection. Asked and answered. You may answer it one more	2 3 4	minutes; correct? A. Yes. Q. With a median of 3 hours, 30 minutes; correct?
2 3 4 5	not? MR. ANDERSON: Objection. Same objection. Asked and answered. You may answer it one more time.	2 3 4 5	minutes; correct? A. Yes. Q. With a median of 3 hours, 30 minutes; correct? A. Yes.
2 3 4 5 6	not?  MR. ANDERSON: Objection. Same objection. Asked and answered.  You may answer it one more time.  THE WITNESS: I assumed since	2 3 4 5 6	minutes; correct? A. Yes. Q. With a median of 3 hours, 30 minutes; correct? A. Yes. Q. Average follow-up was four months
2 3 4 5 6 7	not?  MR. ANDERSON: Objection. Same objection. Asked and answered.  You may answer it one more time.  THE WITNESS: I assumed since it's a Y-shaped mesh specifically for	2 3 4 5 6 7	minutes; correct? A. Yes. Q. With a median of 3 hours, 30 minutes; correct? A. Yes. Q. Average follow-up was four months in this publication; correct?
2 3 4 5 6 7 8	not?  MR. ANDERSON: Objection. Same objection. Asked and answered.  You may answer it one more time.  THE WITNESS: I assumed since it's a Y-shaped mesh specifically for sacrocolpopexy and no other indication for	2 3 4 5 6 7 8	minutes; correct? A. Yes. Q. With a median of 3 hours, 30 minutes; correct? A. Yes. Q. Average follow-up was four months in this publication; correct? A. Correct.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	MR. ANDERSON: Objection. Same objection. Asked and answered. You may answer it one more time.  THE WITNESS: I assumed since it's a Y-shaped mesh specifically for sacrocolpopexy and no other indication for use that it would be gone through the appropriate channels of being approved for use.  BY MR. SNELL: Q. So you assumed. A. Correct. MR. ANDERSON: Asked and answered. BY MR. SNELL: Q. But you do not know; correct? A. No. I tend to trust the companies. Q. Over on the right side A. Page 375? Q. Correct.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	minutes; correct?  A. Yes. Q. With a median of 3 hours, 30 minutes; correct? A. Yes. Q. Average follow-up was four months in this publication; correct? A. Correct. Q. A little bit further down in the Comment section you talk about the placement in a non-invasive fashion while avoiding a midline abdominal incision; correct? A. I have to find out where you are. Q. First paragraph. MR. ANDERSON: I think it's, "The advantage of." THE WITNESS: Oh. "The advantage of using a robotic." Yeah, I see where it says that. Yes. BY MR. SNELL: Q. The midline abdominal incision, am I correct that there can be herniation at

1				
	Page 165			Page 166
1	A. Yes.	1	patients; correct?	
2	Q. Is that what you were referring	2	A. Yes.	
3	to there in that particular sentence?	3	Q. Who had undergone robotic-	
4	A. I wasn't referring to I was	4	assisted laparoscopic sacrocolpopexy at the	
5	referring to everything entailed in doing a	5	Mayo Clinic in the past 18 months; correct?	
6	midline lower abdominal incision, so not	6	I'm looking at the abstract. I'm not trying	
7	just limiting it to hernia.	7	to trick you at all.	
8	(Exhibit Elliott-4 was marked	8	A. I'm trying to find it.	
9	for identification.)	9	Q. Total of 20 patients?	
10	BY MR. SNELL:	10	A. Yeah, I see the 20 patients at	
11	Q. Doctor, I've handed you Exhibit	11	our institution, past 18 months. Yes.	
12	Number 4.	12	Q. So the answer to my question is	
13	This is another publication in	13	yes?	
14	which you are one of the authors from 2004;	14	A. Yes, it is.	
15	correct?	15	Q. And under the "Surgical	
16	A. Yes.	16	technique," this was using that same da	
17	Q. Concerning the gynecologic use of	17	Vinci Surgical System; correct?	
18	robotically assisted laparoscopy, colon,	18	A. Yes.	
19	sacrocolpopexy for the treatment of	19	Q. By the way, back in 2004 how much	
20	high-grade vaginal vault prolapse; correct?	20	did that da Vinci Surgical System cost?	
21	A. Yes.	21	A. I don't know.	
22	Q. This is in the "American Journal	22	Q. You know it cost over a million	
23	of Surgery"; correct?	23	dollars; correct?	
24	A. Yes.	24	A. I just said I don't know.	
25	Q. And this is a series of 20	25	Q. You've never heard or seen in the	
	Page 167			Page 168
1	literature that the cost of a da Vinci	1	Q. Urology?	rage 100
2	Surgical System is over a million dollars.	2	Figure 1 is a similar figure to	
3	A. Well, actually, at Mayo they were	3	what we looked at in your earlier papers	
4	given to me, so they were free.	4	showing the different port placements;	
5	Q. For other institutions that	5	correct?	
6	aren't so fortunate as the Mayo Clinic to		COTTECT:	
· U				
		6	A. It is the same picture.	
7	get free things given to them have you seen	6 7	<ul><li>A. It is the same picture.</li><li>Q. Whose hand is that demonstrating?</li></ul>	
7 8	get free things given to them have you seen in the literature that it may cost over a	6 7 8	<ul><li>A. It is the same picture.</li><li>Q. Whose hand is that demonstrating?</li><li>A. Mine. At least, I assume it's</li></ul>	
7 8 9	get free things given to them have you seen in the literature that it may cost over a million dollars for the da Vinci Surgical	6 7	<ul><li>A. It is the same picture.</li><li>Q. Whose hand is that demonstrating?</li><li>A. Mine. At least, I assume it's</li><li>mine. That's where I stand so</li></ul>	
7 8	get free things given to them have you seen in the literature that it may cost over a million dollars for the da Vinci Surgical System?	6 7 8 9 10	<ul> <li>A. It is the same picture.</li> <li>Q. Whose hand is that demonstrating?</li> <li>A. Mine. At least, I assume it's</li> <li>mine. That's where I stand so</li> <li>Q. Who placed the ports when you do</li> </ul>	
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		1		
	Page 169		Page 1	170
1	Q. So the Silastic Y-graft and the	1	Q. Correct?	
2	silicone Y-sling are both the exact same	2	That was managed with	
3	thing.	3	outpatient transvaginal excision; correct?	
4	A. Correct. Yes.	4	A. Yes.	
5	Q. In this group of 20 patients	5	Q. Significant incontinence was	
6	there were some complications identified on	6	present in 2 of your 20 patients; correct?	
7	Page 54-S; correct?	7	A. Correct.	
8	A. 54-S.	8	Q. Turn to the next page.	
9	MR. ANDERSON: 54. This one	9	A. (Witness complies.)	
10	right here, I think.	10	Q. Does this refresh your	
11	BY MR. SNELL:			
		11	recollection as to what the purchase cost of	
12	Q. Let me just ask a question.	12	a da Vinci Surgical System is	
13	A. Oh. Sorry.	13	A. Yes.	
14	Q. There were some complications	14	Q that you put in your paper?	- 1
15	reported in your paper; correct?	15	A. Yep.	
16	A. Yes.	16	Q. And what is it?	
17	Q. They included mild port site	17	A. \$1 million.	
18	infections in two patients; correct?	18	<ul><li>Q. And in many facilities the cost</li></ul>	
19	A. Yes.	19	is prohibitive; correct?	
20	Q. You had a patient who developed a	20	A. I I I can't agree with	
21	recurrent grade-three rectocele; correct?	21	that, actually, no.	
22	A. Yes.	22	Q. Well, you wrote, Doctor,	
23	Q. Another patient developed a small	23	"Although it is true that the device reduces	
24	erosion six months after the procedure?	24	operative time, for many facilities the cost	
25	A. Yes.	25	is prohibitive"; correct?	
			<u> </u>	_
	Page 171		Page 1	172
1	Page 171 A. Uh-huh. That was in 2004, when I	1	Page 1 O. The series, Doctor, you mentioned	172
1 2	A. Uh-huh. That was in 2004, when I		Q. The series, Doctor, you mentioned	172
2	A. Uh-huh. That was in 2004, when I wrote it. We're talking now 2012.	2	Q. The series, Doctor, you mentioned earlier, was it 30 cases or	172
2 3	A. Uh-huh. That was in 2004, when I wrote it. We're talking now 2012.  Many facilities, if they do not	2 3	Q. The series, Doctor, you mentioned earlier, was it 30 cases or A. I believe 30, yes.	172
2 3 4	A. Uh-huh. That was in 2004, when I wrote it. We're talking now 2012.  Many facilities, if they do not have a robot, will not find themselves	2 3 4	<ul><li>Q. The series, Doctor, you mentioned earlier, was it 30 cases or</li><li>A. I believe 30, yes.</li><li>Q. Can you point me to the</li></ul>	172
2 3 4 5	A. Uh-huh. That was in 2004, when I wrote it. We're talking now 2012.  Many facilities, if they do not have a robot, will not find themselves competitive so many hospitals, even small	2 3 4 5	Q. The series, Doctor, you mentioned earlier, was it 30 cases or A. I believe 30, yes. Q. Can you point me to the publication in your CV? Maybe that will	172
2 3 4 5 6	A. Uh-huh. That was in 2004, when I wrote it. We're talking now 2012.  Many facilities, if they do not have a robot, will not find themselves competitive so many hospitals, even small ones, are buying these. Specifically in	2 3 4 5 6	Q. The series, Doctor, you mentioned earlier, was it 30 cases or A. I believe 30, yes. Q. Can you point me to the publication in your CV? Maybe that will help me find it and we can discuss it. Did	172
2 3 4 5 6 7	A. Uh-huh. That was in 2004, when I wrote it. We're talking now 2012.  Many facilities, if they do not have a robot, will not find themselves competitive so many hospitals, even small ones, are buying these. Specifically in Minnesota, there are hospitals much smaller	2 3 4 5 6 7	Q. The series, Doctor, you mentioned earlier, was it 30 cases or A. I believe 30, yes. Q. Can you point me to the publication in your CV? Maybe that will help me find it and we can discuss it. Did you give it back to me?	172
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1	Page		Page 174
1	Q. So, Doctor, you've been given		correct?
2	Exhibit Number 5; correct?	2	A. That is correct.
3	A. Correct.		Q. Is this a different cohort of
4	Q. This is a paper in which you're	4	patients?
5	one of the co-authors. The title is	5	A. No. It's both. It's included
6	"Long-Term Results of Robotic Assisted	6	it's the entire series. At some point in
7	Laparoscopic Sacrocolpopexy for the	7	time we changed over to using this new mesh.
8	Treatment of High Grade Vaginal Vault	8	Q. So you did at least 20 cases with
9	Prolapse"?	9	the silicone mesh; correct?
10	A. That is correct.	10	A. I would have to whatever
11	Q. And it looks like this was	11	yeah. I know I remember, recall. It was
12	published August 2006 in the Journal of	12	20 patients on that. So I would assume we
13	Urology; correct?	13	used the same silicone mesh on all those.
14	A. Journal of Urology, 2006, yes.	14	Q. And at most, this would be 10 new
15	Q. And was this the paper in which	15	patients with polypropylene mesh.
16	you referred to the 30-patient cohort?	16	A. Yes. Apparently so, yes.
17	A. Yes.	17	Q. Figure 1, the laparoscopic port
18	Q. Doctor, the two articles we	18	placement, is this the same photo that we
19	looked at that you are a co-author in from	19	saw in the earlier two publications from
20	2004 involved 5 patients and then 20	20	2004?
21	patients, they all involved this silicone	21	A. Yes.
22	mesh; correct?	22	Q. What is shown in Figure 2?
23	A. Correct.	23	A. It's a hand-held retractor that's
24	Q. Now, this paper has a photo at	24	used, that I am actually the one holding at
25	Figure 3 of a polypropylene Y-graft;	25	the time of surgery to help facilitate the
	D	175	D 176
1	Page		Page 176
1 2	dissection and placement of the sutures. It's placed into the vagina.	1 2	vision exactly where we want our sutures to
3	· ·	3	go.  O. So this is inserted into the
4	Q. How is this used? A. The patient is	4	Q. So this is inserted into the vagina.
5	Q. Strike that. Let me ask an	5	A. Correct.
6	intelligible question that makes sense on	6	Q. The robot does the dissection
7	the record.	7	then.
8	How is this hand-held vaginal	8	A. Correct.
9	retractor used, as depicted in Figure 3 of	9	Q. Turn to the next page, 658.
10	your	10	
			So two nationts in this sories
	•		So two patients in this series
11	A. Figure 2.	11	have developed small vaginal extrusions of
11 12	A. Figure 2. Q. I'm sorry. Let me try it again.	11 12	have developed small vaginal extrusions of mesh; correct?
11 12 13	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal	11 12 13	have developed small vaginal extrusions of mesh; correct?  A. Yes.
11 12 13 14	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure	11 12 13 14	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six
11 12 13 14 15	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor?	11 12 13 14 15	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct?
11 12 13 14 15 16	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor? A. The patient is in lithotomy	11 12 13 14 15 16	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct?  A. Yes.
11 12 13 14 15 16 17	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor? A. The patient is in lithotomy position, which means she's on her back with	11 12 13 14 15 16 17	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct?  A. Yes. Q. And they were managed with
11 12 13 14 15 16 17 18	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor? A. The patient is in lithotomy position, which means she's on her back with legs in stirrups. The robot is then placed	11 12 13 14 15 16 17 18	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct? A. Yes. Q. And they were managed with transvaginal excision and primary closure;
11 12 13 14 15 16 17 18 19	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor? A. The patient is in lithotomy position, which means she's on her back with legs in stirrups. The robot is then placed between the legs.	11 12 13 14 15 16 17 18 19	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct? A. Yes. Q. And they were managed with transvaginal excision and primary closure; correct?
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11 12 13 14 15 16 17 18 19 20 21 22	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor? A. The patient is in lithotomy position, which means she's on her back with legs in stirrups. The robot is then placed between the legs. This vaginal retractor is, as it says, hand-held, where I am holding it and elevating, retracting, moving the vagina	11 12 13 14 15 16 17 18 19 20 21 22	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct? A. Yes. Q. And they were managed with transvaginal excision and primary closure; correct? A. Yes. Q. Now, by this time in August 2006, had any randomized, controlled trials been
11 12 13 14 15 16 17 18 19 20 21 22 23	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor? A. The patient is in lithotomy position, which means she's on her back with legs in stirrups. The robot is then placed between the legs. This vaginal retractor is, as it says, hand-held, where I am holding it and elevating, retracting, moving the vagina various different directions to aid in the	11 12 13 14 15 16 17 18 19 20 21 22 23	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct? A. Yes. Q. And they were managed with transvaginal excision and primary closure; correct? A. Yes. Q. Now, by this time in August 2006, had any randomized, controlled trials been done on the robotic laparoscopic
11 12 13 14 15 16 17 18 19 20 21 22	A. Figure 2. Q. I'm sorry. Let me try it again. How is this hand-held vaginal retractor used, which is depicted in Figure 2 of your 2006 publication, Doctor? A. The patient is in lithotomy position, which means she's on her back with legs in stirrups. The robot is then placed between the legs. This vaginal retractor is, as it says, hand-held, where I am holding it and elevating, retracting, moving the vagina	11 12 13 14 15 16 17 18 19 20 21 22	have developed small vaginal extrusions of mesh; correct?  A. Yes. Q. Each extrusion developed six months following the procedure; correct? A. Yes. Q. And they were managed with transvaginal excision and primary closure; correct? A. Yes. Q. Now, by this time in August 2006, had any randomized, controlled trials been

1				
1 1	Page 177			Page 178
	MR. SNELL: We've been going	1	A. Yes.	- 1
2	for a while. Why don't we take a little	2	Q. That's where a needle is placed	
3	break.	3	through the abdomen to	
4	MR. ANDERSON: Okay.	4	A. Well, not through.	
5	(Recess, 3:04-3:20 p.m.)	5	Q separate the space?	
6	BY MR. SNELL:	6	A. Not through the abdomen. Into	
7	Q. Doctor, I wanted to circle back	7	the abdomen.	
8	around.	8	Q. Into the abdomen. And it's to	
9	Do you have Exhibit 4 handy?	9	separate the space.	
10	A. Yes, I do.	10	A. Well, it's to fill it with air or	
11	MR. ANDERSON: Let me hold that	11	CO2, yes.	
12	for you.	12	Q. Let's see if we can break that	
13	THE WITNESS: Yes, I have it.	13	down.	
14	BY MR. SNELL:	14	A needle is placed into the	
15	Q. Under the "Surgical technique"	15	abdomen; correct?	
16	A. Okay.	16	A. Correct.	
17	Q on the right side you talk	17	Q. Varus needle, is that a	
18	about patients placed in the dorsal	18	particular type of needle or is that	
19	lithotomy position.	19	A. Yeah, it's a specific type of	- 1
20	Do you see where I'm at?	20	needle. I don't know what gauge it is.	
21	A. Second or first full paragraph,	21	It's a little bit larger, to allow	- 1
22	yes.	22	roughly, it's about 8 centimeters long, to	
23	Q. Yeah. Next paragraph, it says	23	allow the air to get in or the CO2 to get	
24	that abdominal insufflation is performed	24	access into the abdomen.	- 1
25	using a varus needle; correct?	25	Q. And the CO2 is placed through the	
	asing a variab hosaic, correcti		Q. This are est to places allough the	
	Page 179			Page 180
4	needle into the abdomen.			· ·
1 1	necale into the ababilitin	1	SO	
1 2				
2	A. Correct.	1 2 3	Q. I'm not saying that's the	
2	<ul><li>A. Correct.</li><li>Q. And that separates the space.</li></ul>	2	Q. I'm not saying that's the entirety of how you were trained.	
2 3 4	<ul><li>A. Correct.</li><li>Q. And that separates the space.</li><li>A. Well, not separates it. It fills</li></ul>	2 3 4	<ul><li>Q. I'm not saying that's the entirety of how you were trained.</li><li>A. Well, palpate what?</li></ul>	
2 3 4 5	<ul><li>A. Correct.</li><li>Q. And that separates the space.</li><li>A. Well, not separates it. It fills</li><li>it with CO2 so you can see inside. I mean,</li></ul>	2 3 4 5	<ul><li>Q. I'm not saying that's the entirety of how you were trained.</li><li>A. Well, palpate what?</li><li>Q. When you were performing surgical</li></ul>	
2 3 4 5 6	<ul> <li>A. Correct.</li> <li>Q. And that separates the space.</li> <li>A. Well, not separates it. It fills</li> <li>it with CO2 so you can see inside. I mean,</li> <li>technically, yes, separates. Yeah.</li> </ul>	2 3 4 5 6	<ul><li>Q. I'm not saying that's the entirety of how you were trained.</li><li>A. Well, palpate what?</li><li>Q. When you were performing surgical procedures, were you trained to palpate</li></ul>	
2 3 4 5 6 7	<ul> <li>A. Correct.</li> <li>Q. And that separates the space.</li> <li>A. Well, not separates it. It fills</li> <li>it with CO2 so you can see inside. I mean,</li> <li>technically, yes, separates. Yeah.</li> <li>Q. And the abdominal insufflation</li> </ul>	2 3 4 5 6 7	Q. I'm not saying that's the entirety of how you were trained. A. Well, palpate what? Q. When you were performing surgical procedures, were you trained to palpate during those procedures to aid you?	
2 3 4 5 6 7 8	<ul> <li>A. Correct.</li> <li>Q. And that separates the space.</li> <li>A. Well, not separates it. It fills</li> <li>it with CO2 so you can see inside. I mean,</li> <li>technically, yes, separates. Yeah.</li> <li>Q. And the abdominal insufflation</li> <li>using this varus needle is performed</li> </ul>	2 3 4 5 6 7 8	Q. I'm not saying that's the entirety of how you were trained. A. Well, palpate what? Q. When you were performing surgical procedures, were you trained to palpate during those procedures to aid you? A. Well, "palpate" is not a word I	
2 3 4 5 6 7 8 9	A. Correct. Q. And that separates the space. A. Well, not separates it. It fills it with CO2 so you can see inside. I mean, technically, yes, separates. Yeah. Q. And the abdominal insufflation using this varus needle is performed blindly; correct?	2 3 4 5 6 7 8 9	Q. I'm not saying that's the entirety of how you were trained. A. Well, palpate what? Q. When you were performing surgical procedures, were you trained to palpate during those procedures to aid you? A. Well, "palpate" is not a word I use.	
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Correct. Q. And that separates the space. A. Well, not separates it. It fills it with CO2 so you can see inside. I mean, technically, yes, separates. Yeah. Q. And the abdominal insufflation using this varus needle is performed blindly; correct? A. Yes. Q. And there can be injury with abdominal insufflation using a varus needle; correct? A. Yes. Q. And this was known to you back in 2004, when you were performing this part of the procedure; correct? A. Yes. Q. As a surgeon, were you trained to use your hands and palpate during surgery? A. That would be part of it, yes. Q. That's how you were trained; correct?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. I'm not saying that's the entirety of how you were trained. A. Well, palpate what? Q. When you were performing surgical procedures, were you trained to palpate during those procedures to aid you? A. Well, "palpate" is not a word I use. You use all the senses given to you not all of them, majority of them to perform the surgery appropriately. So the tactile feedback and feeling is one of them. I'd prefer to use that as opposed to palpate. Q. So the tactile feeling and feedback is one of the modes in which you were trained on as a surgeon. A. Correct. Q. And you would agree that injury can occur during a surgery, even under direct visualization. A. Yes.	
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		Page 181			Page 182
1	(Exhibit Elliott-6 was marked		1	A. Yes.	İ
2	for identification.)		2	Q. And that was implanted along the	
3	BY MR. SNELL:		3	anterior rectus fascia; correct?	
4	Q. Doctor, you mentioned studies		4	A. Yes.	
5	that you have been involved in on rabbits		5	Q. Figure 1 has a depiction of the	
6	and different types of materials, autologous		6	actual different materials as implanted;	
7	materials, polypropylene.		7	correct?	
8	Was this one of the studies you		8	A. That is correct.	
9	were referring to?		9	Q. And you wanted to investigate	
10	A. Yes.		10	time-dependent variations in tensile	
11	Q. And this was a study that was		11	strength, stiffness, shrinkage, and	
12	published in 2004; correct? May 2004;		12	distortion; correct?	
13	right?		13	A. Yes.	
14	A. May 2004. You are correct.		14	Q. In six materials commonly used	
15	Q. It was a study in 15 rabbits,		15	for transvaginal anti-incontinence surgery;	
16	white New Zealand rabbits, I believe?		16	correct?	
17	A. New Zealand yes, 15 rabbits.		17	A. Yes.	
18	Q. And what you did was each rabbit		18	Q. So shrinkage is one of the things	
19	was implanted with different materials;		19	you looked at in 2004; right?	
20	correct?		20	A. I'm just reviewing the paper.	
21	A. Yes.		21	Q. First line under "Purpose."	
22	Q. Human cadaveric fascia, porcine		22	A. "Purpose." Shrinkage, yes.	
23	dermis, porcine small intestine, submucosa,		23	Q. So you looked at the degree of	
24	polypropylene mesh and autologous fascia;		24	shrinkage with these different materials,	
25	correct?		25	including polypropylene mesh, in 2004;	
23	correct:		25	including polypropylene mesh, in 2004,	
		Page 183			Page 184
1	correct?	Page 183	1	Looking back now, that	Page 184
1 2	correct? A. That is correct.	Page 183	1 2	Looking back now, that increased fibrosis we would say would be	Page 184
2	A. That is correct.	Page 183	2	increased fibrosis we would say would be	Page 184
2	<ul><li>A. That is correct.</li><li>Q. You earlier mentioned strike</li></ul>	Page 183	2	increased fibrosis we would say would be leading to contraction and shrinkage.	Page 184
2 3 4	<ul><li>A. That is correct.</li><li>Q. You earlier mentioned strike that.</li></ul>	Page 183	2 3 4	increased fibrosis we would say would be leading to contraction and shrinkage. Q. Just so I'm clear, this study was	Page 184
2 3 4 5	A. That is correct. Q. You earlier mentioned strike that. You earlier referenced that	Page 183	2 3 4 5	increased fibrosis we would say would be leading to contraction and shrinkage. Q. Just so I'm clear, this study was completed in 2003; correct?	Page 184
2 3 4 5 6	A. That is correct. Q. You earlier mentioned strike that. You earlier referenced that fibrosis was later recognized to be	Page 183	2 3 4	increased fibrosis we would say would be leading to contraction and shrinkage. Q. Just so I'm clear, this study was completed in 2003; correct? A. Yes.	Page 184
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-	Page 185		Page 186	5
1	literature long before that time; correct?	1	intestinal submucosa demonstrated a 41	
2	A. I suppose so, yes. I don't know.	2	percent and 50 percent decrease in surface	
3	Q. The human cadaveric fascia and	3	area respectively at 12 weeks.	
4	porcine allografts showed marked decrease in	4	A. I'm sorry. I lost where you are.	
5	tensile strength; correct?	5	Q. Right there on the "Results"	
6	A. Again, I'd have to go back and	6	section of the abstract of your paper in	
7	look at the paper. Off the top of my	7	2003.	
8	head	8	MR. ANDERSON: Well, he's just	
9	Q. I'm right there, right in the	9	trying to get to the point where you're	
10	"Results."	10	reading from.	
11	MR. ANDERSON: He's looking	11	THE WITNESS: Okay. I heard	
12	at	12	what you had to say. I just wanted to know	
13	THE WITNESS: Yes.	13	where we are. Page 1971, second column.	
14	BY MR. SNELL:	14	BY MR. SNELL:	
15	Q. And they had marked decrease in	15	Q. "Results."	
16	stiffness from baseline; correct?	16	A. "Results."	
17		17		
			Q. At the very front. No. No. I'm	
18	Q. Polypropylene mesh and autologous	18	sorry. Doctor. In the very front, in the	
19	fascia did not differ in tensile strength	19	"Abstract."	
20	from baseline; correct?	20	A. Oh, in the "Abstract." Okay.	
21	A. Yes.	21	Q. So you were looking at the	
22	Q. Polypropylene mesh increased in	22	"Results" section.	
23	stiffness from baseline; correct?	23	A. Yes.	
24	A. Yes.	24	Q. I was looking at the "Results"	
25	Q. The autologous fascia and small	25	part of the abstract. I see. No problem.	
				╝
	Page 187		Page 188	
1	Page 187	1	Page 188	3
1	"Autologous fascia and small	1	mesh erosion in 2003 when you wrote this	3
2	"Autologous fascia and small intestinal submucosa demonstrated a 41% and	2	mesh erosion in 2003 when you wrote this paper; correct?	3
2 3	"Autologous fascia and small intestinal submucosa demonstrated a 41% and 50% decrease in surface area, respectively,	2	mesh erosion in 2003 when you wrote this paper; correct?  A. Yes.	3
2 3 4	"Autologous fascia and small intestinal submucosa demonstrated a 41% and 50% decrease in surface area, respectively, at 12 weeks"; correct?	2 3 4	mesh erosion in 2003 when you wrote this paper; correct?  A. Yes. Q. You were aware of the risk of	3
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2 3 4 5 6	"Autologous fascia and small intestinal submucosa demonstrated a 41% and 50% decrease in surface area, respectively, at 12 weeks"; correct?  A. Yes. Correct. Q. On Page 1970 on the right-hand	2 3 4 5 6	mesh erosion in 2003 when you wrote this paper; correct?  A. Yes. Q. You were aware of the risk of mesh extrusion in 2003 when you wrote this paper; correct?	3
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Page 189 Page 190 1 fascia lata grafts have been shown to retain 1 not at all. It's infectious transmission. 2 antigenicity." 2 Q. So the concern with cadaveric 3 3 A. Uh-huh. fascia lata grafts in this context that you 4 4 wrote in 2003 pertained to the transmission Did I --O. 5 5 Yeah. of infection. Α. 6 6 Q. -- pronounce it correctly? A. Correct. That's specifically 7 Yeah. Pretty good. 7 antigenicity, which you pronounced better A. 8 What is that, Doctor? 8 than I just did, is pertaining to that infectious transmission long term. 9 That just means that -- you know, 9 Α. 10 I'm not an immunologist so I'll give an 10 Q. At the end of that paragraph you 11 infantile answer for it. It is that the 11 say, "The biomechanical results of the theoretical possibility that fascia lata current study support the use of 12 12 polypropylene mesh for sling surgery from a cadaver can still retain some of its 13 13 antigens, so that the body views it as not 14 14 relative to other nonautologous materials"; 15 them. 15 correct? 16 0. And in the literature that's been 16 A. Yes. 17 discussed in the context of patients who 17 (Exhibit Elliott-7 was marked 18 rejects cadaveric slings. 18 for identification.) Not reject. They're worried 19 19 BY MR. SNELL: 20 about the long-term, 20-, 30-, 40-year 20 Q. All right. Doctor, I've handed 21 history with prions, P-R-I-O-N-S, and the 21 you Exhibit Number 7, which is another paper potential transmission of disease processes 22 22 in which you are a co-author on from 2006 -such as Creutzfeldt-Jakob. There's several A. Yes, I have it. 23 23 24 of those names. But no, we're not worried 24 Q. -- in the Journal of Urology; 25 about rejection necessarily. No, actually 25 correct? Page 191 Page 192 Yes. 1 Doctor, any kind of surgery, and you make 1 A. 2 And this was a study that you 2 incisions, the body's natural response is to 3 completed in 2005; correct? 3 try to heal; correct? A. Well, no. The paper was finished 4 4 Α. Yes. 5 in 2005 so I don't know, actually, when the 5 Setting aside cases where 6 study was completed. It would have been in 6 somebody is, you know, highly 7 7 that time frame, 2004, 2005. immunosuppressed, in general, we can agree 8 8 that the body normally tries to heal. Q. And this was another study in 9 rabbits? 9 Α. Yes. 10 A. Correct. Same kind of rabbits, 10 And for a surgery involving basic New Zealand rabbits, I believe. incisions, the body's natural response is to 11 11 O. And one of the things you looked 12 12 try to heal that area and form a scar; at in this study was inflammation associated 13 13 correct? 14 with the different implants; correct? A. I don't know what you mean by the 14 15 Yes. 15 basic incisions. And of the different materials, Q. If an incision is made on your 16 16 arm during surgery to place pins in one of 17 polypropylene mesh had the lowest degree of 17 18 inflammation; correct? 18 the bones, the body's natural response is to That's what we found at our try to heal that incision area and form a 19 19 20 20 scar; correct? 12-week study, yes. Q. Did you ever do a follow-up study 21 21 A. The body -- the body -- the goal to this longer-term data that showed 22 22 of the body is to heal itself, yes. something different than that? 23 23 Correct. 24 Α. No. No. 24 Q. And scar formation is the way 25 25 that the body heals itself. Whenever you do a surgery, Q.

Page 193 Page 194 A. I --There is a whole cascade of 1 1 2 MR. ANDERSON: Objection. 2 events that happens as soon as there is a 3 3 break in the skin and blood is spilled Go ahead. 4 4 because that sets off this cascade, which THE WITNESS: Yes. But in your 5 5 I'm not, by no means, am going to be an example, putting the pins in the body, now 6 you've got a foreign body reaction. So now 6 expert on. But then that sets off 7 the body might not be able to heal itself or 7 platelets, it sets off the immune response, 8 it may go into overdrive and attempt to heal 8 neutrophils, which incorporate macrophages. 9 itself and now you have a -- a poor 9 It is an amazingly complicated and incredible cascade of events. Anything 10 environment for healing. 10 11 BY MR. SNELL: 11 that inhibits that, whether it be a pin in the arm, which can get infected or create 12 Q. You know pins have been used in 12 orthopedic surgeries for decades? any type of foreign body response or 13 13 A. I -- I assume so. I don't know. infection, will -- can inhibit that proper 14 14 Because I'm not an orthopedic surgeon. cascade. 15 15 Q. Explain to me the process, then, Q. How large are neutrophils? 16 16 17 Doctor, by which the body heals itself when That is a question that is still 17 Α. 18 you have something like an incision and you 18 evolving. Again, I'm not an immunologist; put stitches in the incision. How does the however, it depends upon what type of 19 19 20 body go about healing itself? 20 neutrophils you're talking about because neutrophils are different throughout the 21 A. It is an incredibly complicated 21 and still to this date poorly understood body. Are you talking in the lung? Are you 22 22 process. Myself as a urologist are not talking in the pelvis? All the --23 23 24 going to understand all the nuances. 24 Q. Let's talk about neutrophils in 25 Actually, it gets into immunology. 25 the pelvis, neutrophils that are involved in Page 195 Page 196 the body's tissue integration with regard to 1 A. I think the immune system is 1 2 2 insanely complicated. There's no lawyer in pelvic mesh. 3 A. Okay. Now then I'll have to ask 3 this room who understands them. I am a 4 more questions. Is this when these 4 surgeon who has been studying it. I don't 5 neutrophils are at rest, so to speak, or are 5 understand it. And immunologists are just 6 these neutrophils, once they have been 6 beginning to understand it. Okay. 7 activated and are starting to be involved in 7 So I can give you a preliminary 8 8 explanation, actually, from what I've read. phagocytosis and moving around and picking 9 up debris? Because neutrophils, i.e., 9 But, yes, alveolar macrophages, 4,000 macrophages, gobble up -- again, that's not 10 10 microns is in the data out there. 11 a good academic term, but they -- they 11 So when you say neutrophils, incorporate debris. So they can become very you are actually by default saying 12 12 macrophages because that is a subset. 13 large. So I cannot give you --13 Q. Before they incorporate debris. Q. So are alveolar macrophages 14 14 15 I would say you can have a range 15 involved in tissue integration with mesh? of 20 to 80 microns. They sure can be. 16 16 O. So just so I have this correct, I'm not talking about can be. 17 17 I'm asking, are they? I want to know, are 18 neutrophils before they gobble up anything 18 can be up to the size of 80 microns. 19 19 they? 20 A. I've seen reports with 20 MR. ANDERSON: Objection. macrophages up to 4,000 microns. 21 21 Go ahead. 22 Q. Macrophages, yeah. I want to 22 THE WITNESS: Well, I just talk about -answered that. See, the -- what I can -- I 23 23 Well, but that's a subset. can be a smart aleck and say, do you know 24 Α. 24 25 25 what alveolar macrophages are? Okay. Q.

			1
	Page 197		Page 198
1	BY MR. SNELL:	1	thoracic wall hernias.
2	Q. No.	2	Q. But I'm not talking about
3	<ul> <li>A. The answer is going to be no.</li> </ul>	3	thoracic wall hernias right now.
4	Q. But I'm not the doctor.	4	A. I'm sorry. But I was answering
5	A. But if you have thoracic wall	5	your question.
6	hernias that are repaired, then the alveolar	6	If you want to be specific in
7	macrophages can be involved in that, yes.	7	the mesh, that is used for the purpose of
8	Q. I thought we were talking about	8	healing pelvic organ prolapse. Alveolar
9	for prolapse.	9	macrophages are not in that.
10	A. Read your question.	10	Q. Have you seen it reported in the
11	MR. ANDERSON: But you changed	11	medical literature that macrophages that are
12	it to mesh and that's why he was having a	12	associated with tissue integration for mesh
13	problem when you just said mesh.	13	in pelvic organ prolapse are approximately
14	See? Alveolar macrophages	14	20 to 30 microns in size?
15	·	15	
	involved in tissue integration with mesh is		A. Well, that goes back to my
16	what you said.	16	answer. I said 20 up to 80. And I am not
17	MR. SNELL: Okay.	17	an expert in this. I'm just saying what I
18	BY MR. SNELL:	18	have read in the work of others.
19	Q. Are alveolar	19	Q. What type of neutrophils or
20	A. Alveolar.	20	macrophages involved in the tissue response
21	Q alveolar macrophages involved	21	for mesh for pelvic organ prolapse are
22	in tissue integration with the mesh used in	22	between 50 and 80 microns?
23	pelvic organ prolapse?	23	MR. ANDERSON: I'm going to
24	A. Well, the mesh used in pelvic	24	object.
25	organ prolapse can also be used up in	25	He's not being offered as an
	D 400		D 200
1	Page 199	1	Page 200
1	expert in the area of immunology or	1	of these photographs?
2	expert in the area of immunology or pathology or pathophysiology. So with those	2	of these photographs?  A. No. That would have been the
2 3	expert in the area of immunology or pathology or pathophysiology. So with those objections in mind, if you want to continue	2 3	of these photographs?  A. No. That would have been the pathologist. I believe it was Tom Sebo.
2 3 4	expert in the area of immunology or pathology or pathophysiology. So with those objections in mind, if you want to continue asking questions, I'm going to continue	2 3 4	of these photographs?  A. No. That would have been the pathologist. I believe it was Tom Sebo.  Q. Do you know at what power those
2 3 4 5	expert in the area of immunology or pathology or pathophysiology. So with those objections in mind, if you want to continue asking questions, I'm going to continue objecting, but he's not being offered as an	2 3 4 5	of these photographs?  A. No. That would have been the pathologist. I believe it was Tom Sebo.  Q. Do you know at what power those photographs were taken? I didn't see it in
2 3 4 5 6	expert in the area of immunology or pathology or pathology. So with those objections in mind, if you want to continue asking questions, I'm going to continue objecting, but he's not being offered as an expert witness on this.	2 3 4 5 6	of these photographs?  A. No. That would have been the pathologist. I believe it was Tom Sebo.  Q. Do you know at what power those photographs were taken? I didn't see it in here.
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	Page 201		Page 202
1	Figure where I'm just talking about	1	slings, yes.
2	Figure 3.	2	Q. Correct.
3	MR. ANDERSON: That's all	3	And you say, "Our results
4	right.	4	indicated little degree of inflammation";
5	There's not a question pending;	5	correct?
6	right? Because he said I don't see it. You	6	A. Yes.
7	asked him if he saw the magnification and he	7	Q. "And significant fibrosis";
8	said I don't see it.	8	correct?
9	THE WITNESS: I'm sorry. I	9	A. Yes.
10	said I don't see it.	10	Q. "Similar to that of autologous
11	MR. SNELL: Okay. I didn't	11	material"; correct?
12	hear you. I thought you were just looking	12	A. Yes.
13	for the reference to Figure 3.	13	Q. Moving a little further, you also
14	THE WITNESS: I	14	note, none of the material appeared grossly
15	MR. ANDERSON: Off the record.	15	infected at explantation in your study;
		16	
16	(Discussion off the record.)		correct?
17	BY MR. SNELL:	17	A. Yes.
18	Q. At the last page, Doctor, under	18	Q. In this paper you talk about some
19	"As alternatives," looking at the bottom	19	of the limitations of your study; correct?
20	left corner	20	A. Yes.
21	A. I see it, yes.	21	Q. One of it is that you used an
22	Q. So that in this paragraph you're	22	animal model; correct?
23	talking about the use of polypropylene mesh;	23	A. Yes.
24	correct?	24	Q. And there's differences between
25	A. In the setting for mid-urethral	25	humans and animals, obviously; correct?
	Dana 202		Dama 204
1	Page 203	1	Page 204
1	A. Yes.	1	A. I do not believe I have.
2	<ul><li>A. Yes.</li><li>Q. There's differences in studies</li></ul>	2	A. I do not believe I have.     Q. As you sit here today, what is
2	<ul><li>A. Yes.</li><li>Q. There's differences in studies</li><li>that seek to look at clinical conditions in</li></ul>	2 3	A. I do not believe I have. Q. As you sit here today, what is your infection rate for your polypropylene
2 3 4	A. Yes. Q. There's differences in studies that seek to look at clinical conditions in humans and compare those with animal models;	2 3 4	A. I do not believe I have. Q. As you sit here today, what is your infection rate for your polypropylene slings?
2 3 4 5	A. Yes. Q. There's differences in studies that seek to look at clinical conditions in humans and compare those with animal models; correct?	2 3 4 5	A. I do not believe I have. Q. As you sit here today, what is your infection rate for your polypropylene slings? A. Are you talking about vaginal
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2 3 4 5 6 7	A. Yes. Q. There's differences in studies that seek to look at clinical conditions in humans and compare those with animal models; correct? A. Yes. Q. Towards the end you note in the	2 3 4 5 6 7	A. I do not believe I have. Q. As you sit here today, what is your infection rate for your polypropylene slings? A. Are you talking about vaginal extrusion or infection of the mesh? Because there's a like I said, I just want
2 3 4 5 6 7 8	A. Yes. Q. There's differences in studies that seek to look at clinical conditions in humans and compare those with animal models; correct? A. Yes. Q. Towards the end you note in the "Conclusions" section, "These results add	2 3 4 5 6 7 8	A. I do not believe I have. Q. As you sit here today, what is your infection rate for your polypropylene slings? A. Are you talking about vaginal extrusion or infection of the mesh? Because there's a like I said, I just want clarification of what you're asking.
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	Page 205	1	evoluting it they appear to be very	Page 206
1	making that statement, I excluded the OB	1	eyeballing it, they appear to be very	
2	tape. Our series of OB tapes, which are no	2	similar.	
3	longer on the market, we had 8 out of 100	3	Q. Now, you also mentioned	
4	become infected, very significant, severe	4	extrusion	
5	infections. Okay. So when I I gave that	5	A. Extrusion.	
6	number, I actually should preface by	6	Q when you were asking me for	
7	excluding OB Tape.	7	clarification?	
8	Q. Well, the 1,500 slings that you	8	A. Yes.	
9	identified, you have one mesh infection out	9	Q. In these 1,500 polypropylene	
10	of, let's just focus on that one.	10	slings, can you tell me what your extrusion	
11	A. Correct.	11	rate was?	
12	Q. That's a macroporous sling;	12	<ul> <li>A. Excluding the OB Tape.</li> </ul>	
13	correct?	13	<ul><li>Q. Let's just set that aside.</li></ul>	
14	A. It's the SPARC suburethral sling,	14	A. It's two that I know of.	
15	so I don't know as far as the macroporous.	15	Q. Two of 1,500?	
16	It's	16	A. Correct.	
17	Q. Do you know if it's a larger pore	17	Q. Have you ever published on the	
18	size than the OB Tape?	18	rate of mesh exposure or extrusion in the	
19	A. Yes, definitely, it is.	19	abdominal sacrocolpopexies that you have	
20	Q. Do you know how that pour size of	20	done?	
21	the SPARC tape compares to the pour size of	21	A. We have not published	
22	the mesh used with, say, TVT®-O?	22	specifically on it; however, it is	
23	A. All I would be able to do is not	23	referenced in the manuscripts.	
24	on a scientific level, of saying just	24	Q. Sorry. My question was about the	
25	eyeballing it, for lack of a better phrase,	25	abdominal sacrocolpopexies.	
	Page 207			Page 208
1	A. Oh, sorry.	1	that.	
2	Q. Let me just check my question and	2	Q. Have you ever published on your	
3	make sure that was what I thought.	3	experience in abdominal sacrocolpopexy?	
4	MR. ANDERSON: You were right.	4	A. No.	
5	THE WITNESS: Yeah. I	5	Q. Have you ever presented on your	
6	misunderstood your question. I'm sorry.	6	experience with abdominal sacrocolpopexy	
7	MR. SNELL: That's okay.	7	with like a poster or, you know, a meeting,	
8	BY MR. SNELL:	8	anything like that?	
9	Q. Let me just ask, have you ever	9	A. No.	
10	published on the rate of mesh exposure or	10	Q. Are there any studies or	
11	extrusion in the abdominal sacrocolpopexies	11	publications or presentations that you have	
12	that you have done?	12	been involved with which concern the use o	f
13	A. No, I have not.	13	mesh to treat either stress urinary	
14	Q. Do you know the rate of mesh	14	incontinence or prolapse that are not	
1 🗆		145	included in your CV?	
15	exposure for the abdominal sacrocolpopexies	15	mended in your ev.	
16	exposure for the abdominal sacrocolpopexies that you have performed?	16	MR. ANDERSON: Objection.	
	• • • • • • • • • • • • • • • • • • • •		•	
16	that you have performed?	16	MR. ANDERSON: Objection.	
16 17	that you have performed?  Well, let me back up, actually.  Maybe you told me this before, and if you	16 17	MR. ANDERSON: Objection. MR. SNELL: Can you tell me	
16 17 18 19	that you have performed?  Well, let me back up, actually.  Maybe you told me this before, and if you did, I apologize, because I've forgotten,	16 17 18	MR. ANDERSON: Objection. MR. SNELL: Can you tell me what's wrong, Counsel? I just want to	
16 17 18	that you have performed?  Well, let me back up, actually.  Maybe you told me this before, and if you did, I apologize, because I've forgotten, clearly.	16 17 18 19	MR. ANDERSON: Objection. MR. SNELL: Can you tell me what's wrong, Counsel? I just want to MR. ANDERSON: That he's been involved with. I don't know	
16 17 18 19 20 21	that you have performed?  Well, let me back up, actually.  Maybe you told me this before, and if you did, I apologize, because I've forgotten, clearly.  How many abdominal	16 17 18 19 20 21	MR. ANDERSON: Objection. MR. SNELL: Can you tell me what's wrong, Counsel? I just want to MR. ANDERSON: That he's been involved with. I don't know MR. SNELL: Okay. That's fair.	
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Page 209 Page 210 No. What we're doing is we're 1 been a co-author on or the presenter on that 1 2 concern the use of mesh to treat urinary 2 comparing moderate -- normal BMI to 3 3 incontinence or prolapse that are not enlarged, elevated BMI. 4 identified in your CV? 4 Q. So is it normal BMI as compared 5 5 No. Specifically, to answer your to overweight and obese, as defined by the BMI scale, CDC, or normal weight versus 6 question, no; however, we have submitted for 6 7 meetings, like the SUFU meeting in February, 7 obese BMI of 30 or above? 8 robotic sacrocolpopexy in obese patients, 8 A. Your first statement, that we are 9 and so -- but that has not been presented. 9 comparing the various BMIs, so we have --Q. Got you. Q. Okav. 10 10 11 And then we will be submitting to 11 -- normal, mildly elevated and A. then morbidly obese. 12 the AUA that manuscript and then the other 12 Q. Is this a retrospective cohort 13 one is artificial -- so no, that would be --13 there is no publication pending out there 14 14 study? that I'm aware of off the top of my head 15 15 A. Yes. other than those two presentations. So within the 90 patients for 16 16 Q. O. And both of those involved whom you have been involved with robotic 17 17 18 robotic sacrocolpopexy in an obese cohort? 18 laparoscopic sacrocolpopexy, that's the cohort and it's just stratified by BMI 19 19 A. Correct. 20 Q. How large of a series is this 20 category. obese cohort? 21 A. Correct. 21 22 A. I believe it's involving all of 22 Q. Were there any findings that you considered significant or specific -- strike 23 our 90 patients. 23 24 Q. Were all of the 90 patients 24 that. 25 25 Were there any findings in this obese? Page 211 Page 212 study which you considered to be specific to 1 somewhat because we felt that robotics would 1 2 the use of mesh? 2 actually reduce that, but still it was 3 A. No. It would be specific to 3 reduced compared to open but still 4 significant increased risk compared to thin. 4 obesity and its impact upon robotic 5 sacrocolpopexy. 5 Thin is easy, obese is difficult. 6 Q. What effect, if any, did the 6 Q. And the obese cohort had a longer 7 7 procedure time, in general? obesity have? 8 8 A. Slightly. Yeah, it was 20 to 30 A. The very impressive data that the larger an individual is as far as obese, the 9 9 minutes longer. 10 complications increased. There's almost a 10 Q. Any difference in the rate of linear one-to-one association as far as mesh exposure or extrusion? 11 11 A. We haven't had any beyond our 12 12 that. first eight patients. Our first eight 13 Q. Any particular type of 13 complications or just overall? patients, which is described in that study 14 14 15 A. Overall, and wound infection, 15 of 30, we had, I believe, two and I think we delayed hospital stay, increased risk for had one after that, a total of three 16 16 bleeding and also longer procedure. patients with mesh extrusion, which were all 17 17 18 Q. Do you know why there was an 18 in the first eight or nine, maybe ten increased risk of wound infection with the patients. Since that, the subsequent 80, 19 19 20 obese cohort? 20 we've had zero mesh extrusion. Q. That you're aware of; correct? 21 A. Basically, there's a lot of fat. 21 22 The more fat -- fat does not heal well at 22 That I'm aware of, ves. all. So that goes for plastic surgery, And I also forgot, so just in 23 23 general surgery, and this robotics. case you look it up, the SUFU, we are 24 24 25 That would have surprised us 25 presenting 100 urethrolyses for obstruction

	Page 213		Page 214
1	following slings. That's at the AUA. I'm	1	(Recess, 4:13-4:32 p.m.)
2	sorry.	2	MR. SNELL: Could we mark this.
3	Q. What's a urethrolysis?	3	(Exhibit Elliott-8 was marked
4	A. Oh. Cutting of sling. They're	4	for identification.)
5	obstructed. And that's, again, at the AUA,	5	BY MR. SNELL:
6	not the SUFU. I'm sorry.	6	Q. Doctor, I've handed you Exhibit
7	Q. What types of slings are these?	7	Number 8. You see it's a document that
8	A. The majority are autologous, 53;	8	states that you have been paid one thousand,
9	30, roughly, are synthetics, suprapubic or	9	six hundred back up.
10	TVT®; they had a few transobturators and	10	Doctor, I've handed you Exhibit
11	then some Burch and MKs. That was the	11	Number 8.
12		12	
	minority.		Do you have it in front of you?
13	Q. Where did these cases come from?	13	A. Yes, I do.
14	Were they original surgeries done at Mayo or	14	Q. And that document states that you
15	somewhere else?	15	have been paid \$167,727 to date; correct?
16	A. No. They were all referred in.	16	A. That's what it states, yes.
17	Q. So the majority of these	17	Q. And that document is dated
18	urethrolyses involved autologous slings?	18	October 17th, 2012; correct?
19	A. Correct.	19	A. Correct.
20	Q. What was the N on the obese	20	Q. And is it correct that as of
21	cohort?	21	October 17th, 2012, you have been paid
22	A. 90. Oh, on the obese, the	22	\$167,727?
23	subset? I don't recall.	23	A. Well, as I stated before, I don't
24	MR. SNELL: Take another little	24	know how much I've been paid, but that's how
25	break, if you don't mind.	25	much it states here. I have no reason to
	, , , , , , , , , , , , , , , , , , , ,		
	Page 215		Page 216
1	Page 215 suspect it's wrong.	1	Page 216 evening I put in another hour to two hours.
1 2	suspect it's wrong.		evening I put in another hour to two hours.
2	suspect it's wrong. Q. Now, your rate is \$700 an hour	2	evening I put in another hour to two hours.  And the same would be said then for
2 3	suspect it's wrong. Q. Now, your rate is \$700 an hour even though that document states it is 750;	2 3	evening I put in another hour to two hours. And the same would be said then for Wednesday. Essentially, the roughly, the
2 3 4	suspect it's wrong. Q. Now, your rate is \$700 an hour even though that document states it is 750; correct?	2 3 4	evening I put in another hour to two hours. And the same would be said then for Wednesday. Essentially, the roughly, the same amount.
2 3 4 5	suspect it's wrong. Q. Now, your rate is \$700 an hour even though that document states it is 750; correct? A. Yes. It is 700 but, you know, it	2 3 4 5	evening I put in another hour to two hours. And the same would be said then for Wednesday. Essentially, the roughly, the same amount. Q. Roughly somewhere between 10 and
2 3 4 5 6	suspect it's wrong. Q. Now, your rate is \$700 an hour even though that document states it is 750; correct? A. Yes. It is 700 but, you know, it does say 750. But yes, I am getting paid	2 3 4 5 6	evening I put in another hour to two hours. And the same would be said then for Wednesday. Essentially, the roughly, the same amount. Q. Roughly somewhere between 10 and 14 hours on Tuesday and Wednesday
2 3 4 5 6 7	suspect it's wrong. Q. Now, your rate is \$700 an hour even though that document states it is 750; correct? A. Yes. It is 700 but, you know, it does say 750. But yes, I am getting paid 700 per hour.	2 3 4 5 6 7	evening I put in another hour to two hours. And the same would be said then for Wednesday. Essentially, the roughly, the same amount. Q. Roughly somewhere between 10 and 14 hours on Tuesday and Wednesday A. Correct.
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2 3 4 5 6 7 8 9 10 11	suspect it's wrong. Q. Now, your rate is \$700 an hour even though that document states it is 750; correct? A. Yes. It is 700 but, you know, it does say 750. But yes, I am getting paid 700 per hour. Q. When did you arrive in New Jersey to give your deposition? A. Monday night, whatever that was. Touched down at 11:00 at night.	2 3 4 5 6 7 8 9 10 11	evening I put in another hour to two hours.  And the same would be said then for Wednesday. Essentially, the roughly, the same amount.  Q. Roughly somewhere between 10 and 14 hours on Tuesday and Wednesday A. Correct. Q altogether. A. Correct. That is correct. Each day. Q. Per day.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	suspect it's wrong. Q. Now, your rate is \$700 an hour even though that document states it is 750; correct? A. Yes. It is 700 but, you know, it does say 750. But yes, I am getting paid 700 per hour. Q. When did you arrive in New Jersey to give your deposition? A. Monday night, whatever that was. Touched down at 11:00 at night. Q. How many hours have you spent preparing for this deposition between the time when you got on the plane to come to New Jersey up until this morning before you sat down? A. Okay. Travel time was six, seven hours. I don't know what it was. But there was no prep time in it. That was just travel. And then in the morning of Tuesday there was an hour and a half, two	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	evening I put in another hour to two hours. And the same would be said then for Wednesday. Essentially, the roughly, the same amount. Q. Roughly somewhere between 10 and 14 hours on Tuesday and Wednesday A. Correct. Q altogether. A. Correct. That is correct. Each day. Q. Per day. A. Per day. And then this morning, roughly an hour and a half. Q. So somewhere between 22 and 28 hours, altogether. A. Yeah. I'd have to add it up, but that sounds about right, yeah. Q. And you haven't billed for that, obviously. A. No, I have not. Yes. Q. When was the last time you issued a bill?

	Page 217		Page 218
1	A. Yes. If I've done work, I bill,	1	1st until leaving of doing review work. I
2	obviously.	2	don't know what I I do have a record
3	Q. Besides the 22 to 28 hours that	3	of it. I don't have it with me. That's at
4	you've spent strike that.	4	my home. And I don't know the number of
5	Do you know if this \$167,727	5	hours. It would be in the range of 20 to
6	includes your bill from October 2011?	6	30, maybe. Maybe. I could be quite off,
7	A. I would assume it did not because	7	actually.
8	I submitted it to them on October 31st.	8	Q. So approximately 20
9	Q. Can you give me your best	9	A. 20 to 30.
10	approximation how many hours you billed for	10	Q to 30 hours.
11	in October?	11	A. Prior to leaving to come to New
12	A. I don't know the number of hours	12	Jersey.
13	on that.	13	Q. And approximately 22 to 28 hours
14	Q. Your best approximation is	14	since you've arrived here in New Jersey.
15	that	15	A. Correct. Except that has not
16	A. I can give you a dollar amount	16	not counted the deposition today. So
17	because I know that because I just deposited	17	Q. Yeah.
18	the check.	18	A each minute counts.
19	Q. Okay.	19	Q. Do you have a separate company
20	A. It was roughly 25,000.	20	which the checks are made payable to?
21	Q. And for the month of November,	21	A. No.
22	other than the 22 to 28 hours you spent	22	Q. They're just made out to you
23	preparing in the past couple of days, have	23	personally?
24	you spent any other time on this matter?	24	A. Correct.
25	A. Yeah. I continued from November	25	Q. Did you seek any approval from
	Page 210		Page 220
1	Page 219 the Mayo Clinic with regard to your role as	1	Page 220 Q. Are all opinions you plan to
2	an expert in the mesh litigation?	2	offer, are all your general opinions that
3	A. No. This is all private time.	3	you plan to offer contained within this June
4	Q. Do you have your report handy,	4	15th, 2012, report and the supplemental
5	the annotated one?	5	November 14th, 2012, report, which you state
6	A. Yes, I do.	6	that they further supported your opinions as
7	Q. Is that your version of the	7	set forth in the original report?
8	report?	8	MR. ANDERSON: Just objection
9	A. No.	9	to the question.
10	MR. ANDERSON: It's mine.	10	THE WITNESS: I cannot say. I
11	THE WITNESS: This is	11	mean, I am ongoing continuing to do research
12	Mr. Anderson's.	12	and thought with this. If something new
13	BY MR. SNELL:	13	does arrive, that could change it, but right
14	Q. The November 7th, 2012,	14	now I have no knowledge of anything.
15	supplemental report to which we have	15	BY MR. SNELL:
16		16	Q. As we sit here today, all of your
1 10	objected and I ve stated our grounds for	10	
17	objected and I've stated our grounds for said objection	17	general opinions are contained in the
	•		general opinions are contained in the general report and the November 14th, 2012,
17	said objection	17	
17 18	said objection MR. ANDERSON: Yes.	17 18	general report and the November 14th, 2012,
17 18 19	said objection MR. ANDERSON: Yes. BY MR. SNELL:	17 18 19	general report and the November 14th, 2012, supplement; correct?
17 18 19 20	said objection MR. ANDERSON: Yes. BY MR. SNELL: Q you did not in that report	17 18 19 20	general report and the November 14th, 2012, supplement; correct? MR. ANDERSON: Objection.
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17 18 19 20 21 22 23	said objection MR. ANDERSON: Yes. BY MR. SNELL: Q you did not in that report disclose any new general opinions; correct? MR. ANDERSON: Objection. THE WITNESS: No. That was	17 18 19 20 21 22 23	general report and the November 14th, 2012, supplement; correct?  MR. ANDERSON: Objection.  Go ahead.  THE WITNESS: Yes.  BY MR. SNELL:

	Page 221			Page 222
1	A. Yes.	1	Is it your opinion that any	
2	Q. And that's Pages 8 to 11?	2	non-absorbable transvaginal synthetic mesh	
3	A. Yes.	3	for the use in pelvic organ prolapse is not	
4	Q. And do you believe that this is a	4	an appropriate option for surgeons?	
5	fair summary of the opinions you plan to	5	A. That's not what I state.	
6	offer at trial?	6	Q. I'm asking	
7	A. Yes.	7	A. That's just what I state right	
8	Q. I'm going to ask you about a	8	here. Not demonstrable improvements in	
9	couple of these.	9	symptomatic results over the traditional	
10	The first one are you with	10	repair.	
11	me?	11	Q. My question is, is it your	
12	A. Yes, I am. Number one, I assume	12	opinion that doctors should not use	
13	but	13	non-absorbable transvaginal synthetic mesh	
14	Q. Yes.	14	for pelvic organ prolapse?	
15	A. On Page 8. Yes?	15	A. My opinion, again, we've got it	
16	Q. Page 8. Yes. Thank you, Doctor.	16	outlined very well in here, stated but,	
17	This says, "patients implanted	17	briefly, my opinion is the routine, common	
18	with non-absorbable, transvaginal synthetic	18	use of mesh for pelvic organ prolapse is not	
19	mesh for pelvic organ prolapse, including	19	appropriate, based upon the data.	
20	the Prolift System, do not have demonstrable	20	Q. Do you believe a surgeon who	
21	improvement in symptomatic results over	21	chooses to use transvaginal mesh to treat	
22	traditional, non-mesh repair"; correct?	22	prolapse is violating the standard of care	
23	A. Yes.	23	by using transvaginal mesh	
24	Q. You have reviewed clinical	24	MR. ANDERSON: Objection.	
25	studies let me back up.	25	BY MR. SNELL:	
	Page 223			Page 224
1	Page 223 Q for prolapse?	1	A. There is as you stated that	Page 224
1 2		1 2	A. There is as you stated that	Page 224
2	Q for prolapse? MR. ANDERSON: Sorry.			Page 224
2	Q for prolapse?	2	A. There is as you stated that question, just now Q. Yes.	Page 224
2 3 4	Q for prolapse? MR. ANDERSON: Sorry. Objection.	2	<ul> <li>A. There is as you stated that question, just now</li> <li>Q. Yes.</li> <li>A there is a, I think, a benefit</li> </ul>	Page 224
2 3 4 5	<ul> <li>Q for prolapse?</li> <li>MR. ANDERSON: Sorry.</li> <li>Objection.</li> <li>Go ahead.</li> <li>THE WITNESS: I don't believe a</li> </ul>	2 3 4 5	A. There is as you stated that question, just now Q. Yes. A there is a, I think, a benefit in stress urinary incontinence.	Page 224
2 3 4 5 6	Q for prolapse? MR. ANDERSON: Sorry. Objection. Go ahead. THE WITNESS: I don't believe a standard a standard of care let me	2 3 4 5 6	A. There is as you stated that question, just now Q. Yes. A there is a, I think, a benefit in stress urinary incontinence. Q. Do all patients who receive	Page 224
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		Page 225		Pa	ige 226
1	MR. SNELL: Move to strike	_	1	THE WITNESS: No.	·
2	everything after "I do agree with that."		2	MR. SNELL: Okay.	
3	BY MR. SNELL:		3	BY MR. SNELL:	
4	Q. You would agree that patients		4	Q. Patients implanted with Prolift®,	
5	implanted with Prolift® have demonstrated		5	in general, have improvement in their PSI	
6	improvement in symptomatic results,		6	scores; correct?	
7			7	· · · · · · · · · · · · · · · · · · ·	
	according to the medical literature?			MR. ANDERSON: Objection.	
8	A. Yeah.		8	Go ahead.	
9	MR. ANDERSON: Objection.		9	THE WITNESS: I can't answer	
10	THE WITNESS: Yes.		10	that.	
11	BY MR. SNELL:		11	BY MR. SNELL:	
12	Q. You would agree that patients		12	Q. Why not?	
13	implanted with Prolift® have demonstrated		13	A. Because there is an extensive	
14	improvements in quality of life, according		14	amount of data out there that mesh	
15	to the medical literature.		15	degradation, shrinkage, contraction, et	
16	A. Yes, some of them have. Yes.		16	cetera, continues for years, so I cannot	
17	Q. That's what I'm asking.		17	comment what will be happening 10, 20, 30	
18	Some patients, not every single		18	years on down the road.	
19	one; right, Doctor? Because is there a		19	Your comment in general implies	
20	surgical procedure you can point me to to		20	51 percent, and I don't know, will we cross	
21	treat prolapse where every patient has		21	that at some point in time.	
22	efficacy and no complications?		22	Q. Overall, patients who have been	
23	•		23		.
	MR. ANDERSON: Objection to the			implanted with Prolift® have had improvement	١ ١
24	form.		24	in their anatomic prolapse scoring; correct?	
25	Go ahead.		25	MR. ANDERSON: Objection.	
		Page 227			ige 228
1	Go ahead.	Page 227	1	Go ahead.	ige 228
2	THE WITNESS: And your	Page 227	2	Go ahead. THE WITNESS: I believe the	ige 228
2	THE WITNESS: And your definition of overall is just so I'm	Page 227	2	Go ahead. THE WITNESS: I believe the anatomic repair has been vastly and	ige 228
2 3 4	THE WITNESS: And your definition of overall is just so I'm clear, so I'm answering your question,	Page 227	2 3 4	Go ahead. THE WITNESS: I believe the anatomic repair has been vastly and incorrectly reported as being good. And	age 228
2	THE WITNESS: And your definition of overall is just so I'm	Page 227	2	Go ahead. THE WITNESS: I believe the anatomic repair has been vastly and	ge 228
2 3 4	THE WITNESS: And your definition of overall is just so I'm clear, so I'm answering your question,	Page 227	2 3 4	Go ahead. THE WITNESS: I believe the anatomic repair has been vastly and incorrectly reported as being good. And	ge 228
2 3 4 5	THE WITNESS: And your definition of overall is just so I'm clear, so I'm answering your question, overall means?	Page 227	2 3 4 5	Go ahead. THE WITNESS: I believe the anatomic repair has been vastly and incorrectly reported as being good. And then to answer your question, yes, I agree, Prolift® has anatomic improvement in the	nge 228
2 3 4 5 6	THE WITNESS: And your definition of overall is just so I'm clear, so I'm answering your question, overall means? BY MR. SNELL: Q. The majority.	Page 227	2 3 4 5 6	Go ahead. THE WITNESS: I believe the anatomic repair has been vastly and incorrectly reported as being good. And then to answer your question, yes, I agree, Prolift® has anatomic improvement in the majority of patients.	nge 228
2 3 4 5 6 7 8	THE WITNESS: And your definition of overall is just so I'm clear, so I'm answering your question, overall means?  BY MR. SNELL:  Q. The majority.  A. The majority.	Page 227	2 3 4 5 6 7	Go ahead. THE WITNESS: I believe the anatomic repair has been vastly and incorrectly reported as being good. And then to answer your question, yes, I agree, Prolift® has anatomic improvement in the majority of patients.  MR. SNELL: Move to strike.	nge 228
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		Page 229		Page 230
1	the time," et cetera; correct?		1	THE WITNESS: With the
2	A. Yes.		2	available data present, readily present in
3	Q. If a surgeon has used Prolift®		3	the literature, with no improvement in
4	and he or she believes that it has, in		4	symptomatic results, regardless of what a
5	general, benefitted his or her patients		5	surgeon believes, they are taking those
6	A. There was no question there, was		6	patients and increasing their potential risk
7	there?		7	for devastating complications.
8	Q. No. I'm in the process of		8	I would be very confident and
9	formulating it.		9	have at meetings stated surgeons better be
10	MR. ANDERSON: Formulating.		10	very, very careful in selecting these
11	THE WITNESS: You looked at me.		11	individuals because they are going to be
12	I thought		12	damaging some people permanently.
13	MR. ANDERSON: Off the record.		13	BY MR. SNELL:
14	(Discussion off the record.)		14	Q. I thought we earlier agreed that,
15	BY MR. SNELL:		15	in general, patients who have received
16	Q. If a surgeon has used strike		16	Prolift®, per the medical literature, do
17	that.		17	receive symptomatic improvements.
18	If a surgeon used Prolift® in		18	A. I agree with that.
19			19	
20	his or her patients and they believe that			Q. You just made a statement that there was no improvement of symptomatic
	Prolift®, in general, benefitted his or her		20	• • • • • • • • • • • • • • • • • • • •
21	patients, would you be critical of that		21	results in your previous answer.
22	surgeon's decision to continue to use		22	Were you taking making some
23	Prolift®?		23	type of comparison or
24	MR. ANDERSON: Objection.		24	A. I see.
25	Go ahead.		25	Q. I just don't track you.
		D 224		p 222
1	A No Trainmaka	Page 231	4	Page 232
1	A. No. I misspoke.	Page 231	1	colporrhaphy in that primary composite end
2	In comparison what I should	Page 231	2	colporrhaphy in that primary composite end point; correct?
2	In comparison what I should have stated in there is no symptomatic	Page 231	2	colporrhaphy in that primary composite end point; correct?  A. Now, is this the manuscript where
2 3 4	In comparison what I should have stated in there is no symptomatic improvement in comparison to traditional	Page 231	2 3 4	colporrhaphy in that primary composite end point; correct?  A. Now, is this the manuscript where he states in there there was no Ethicon
2 3 4 5	In comparison what I should have stated in there is no symptomatic improvement in comparison to traditional repair.	Page 231	2 3 4 5	colporrhaphy in that primary composite end point; correct?  A. Now, is this the manuscript where he states in there there was no Ethicon involvement to The New England Journal of
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			1
	Page 233		Page 234
1	colporrhaphy in the primary end point;	1	THE WITNESS: How can how
2	correct?	2	can I trust it? I mean, I
3	A. I will politely, not to be	3	BY MR. SNELL:
4	difficult, refuse to answer that question	4	Q. I'm asking you, are you aware?
5	because this is medical/scientific fraud.	5	A. I am aware
6	Altman lied on that declaration	6	MR. ANDERSON: Same objection.
7	to The New England Journal of Medicine. I	7	THE WITNESS: I am aware in the
8	cannot trust any of that data on there.	8	deposition of Hinoul
9	This is based upon my experience as being an	9	MR. ANDERSON: Hinoul?
10	editor and reviewer in eight different	10	THE WITNESS: Hinoul where
11	medical journals.	11	he describes changes that were made in the
12	If anybody were to know that	12	manuscript.
13	there was a lie like that, that data is	13	I cannot trust the data and nor
14	excluded, he would never be allowed to	14	can any urologist or gynecologist.
15	publish in the United States. So I cannot	15	MR. SNELL: Objection. Move to
16	trust that data at all, no matter what was	16	strike.
17	said.	17	BY MR. SNELL:
18	MR. SNELL: Objection. Move to	18	Q. So you can't answer any questions
19	strike.	19	about the Altman study because of this issue
20	BY MR. SNELL:	20	you've identified.
21	Q. Are you aware of any changes with	21	A. Anything I state about the data
22	the underlying data, with the whole, entire	22	in there, I can't believe that necessarily
23	transvaginal Nordic group during the	23	that data is true.
24	collection of that study?	24	Q. So you don't believe the rate of
25	MR. ANDERSON: Objection.	25	erosion in that study?
	Thu 7 a 12 En Conti Conjection		crosion in charactery.
	Page 235		Page 236
1	Page 235 A. I don't know.	1	Page 236 the data.
1 2	A. I don't know.	1 2	
	A. I don't know.		the data. BY MR. SNELL:
2	<ul><li>A. I don't know.</li><li>Q. You don't</li><li>A. Everything is suspect.</li></ul>	2	the data.
2 3	<ul><li>A. I don't know.</li><li>Q. You don't</li><li>A. Everything is suspect.</li><li>Q. You don't</li></ul>	2	the data. BY MR. SNELL: Q. And, therefore, you're not prepared to answer questions about it, other
2 3 4	<ul> <li>A. I don't know.</li> <li>Q. You don't</li> <li>A. Everything is suspect.</li> <li>Q. You don't</li> <li>A. That paper will get rejected from</li> </ul>	2 3 4	the data. BY MR. SNELL: Q. And, therefore, you're not
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Page 237 Page 238 in her supplemental report details 1 1 you talk about in comparison to traditional repairs, what repairs are you referring to? 2 extensively the changes, subsequently, 2 3 everything is suspect. The complications 3 A. Well, that's going to be specific 4 that -- he reports 16.9 percent erosion. 4 if we're talking about anterior Prolift® and 5 5 How do I know it's not 24? How do I know we're comparing it to anterior colporrhaphy. 6 it's not 5? I can't trust it. 6 Q. Okav. 7 MR. SNELL: Okay. Move to 7 A. If we're talking about posterior 8 8 colporrhaphy, then we're talking about strike. posterior Prolift®, and then total Prolift® 9 9 MR. ANDERSON: That was your is then the various different procedures, 10 question. 10 11 THE WITNESS: It is an issue of 11 which there are going to be several in 12 12 there. integrity. 13 BY MR. SNELL: 13 Can you give me those? Well, there would be sacrospinous 14 Q. When you said there was no 14 improvement in symptomatic results in fixation, sacrocolpopexies, and then again 15 15 comparison to traditional repairs, are you we're probably talking about the McCall's 16 16 basing that on -- on Page 14, the up-to-date culdoplasty, the Mayo culdoplasty. There's 17 17 18 prolapse definitions as articulated by 18 other ones in there. Those are going to be the major percentage-wise. 19 Dr. Weber? 19 20 20 Q. Is it correct that in patients A. That was pertaining to anatomic who have prolapse in more than just the 21 results. I have a detailed explanation in 21 vaginal vault, if a doctor chooses to do a 22 my expert report, Page -- beginning on Page 22 38 where I talk about symptomatic results, sacrocolpopexy in the majority of cases, 23 23 24 which spells it out in detail. 24 they will also do a concomitant adjunct 25 procedure like a colporrhaphy or something 25 And just so I'm clear, too, when Page 239 Page 240 else? 1 pictures that you saw were using, having 1 2 Well, your question is more than 2 those anterior and posterior arms, which are 3 the vaginal vault. The vaginal vault is 3 quite long. That way, you can elevate the 4 everything. So, I mean, are you referring 4 entire vaginal vault with that, anterior, 5 to something else? 5 posterior, and apical. 6 The vaginal vault is implying, 6 There have been descriptions of 7 7 I mean, everything is coming on out, the just putting a cap at the apex of the 8 entire eversion of the vagina, so, by 8 vagina. If you do that, you will not be 9 definition, that's anterior, posterior and 9 supporting anterior or posterior, at least 10 apical. So are you referring to something 10 very well. else, suggesting that I'm missing? Q. Okay. 11 11 And so then that answers your 12 12 Q. 13 A. I think I'm missing the question, 13 question, would they do a concurrent 14 anterior/posterior colporrhaphy. I do not then. 14 15 Yeah, I think we're not 15 in my practice. Q. communicating. Q. Are you familiar with the 16 16 Well, let me ask it this way: 17 randomized, controlled trial by Withagen --17 18 Are concomitant prolapse surgeries commonly 18 A. Yes. done alongside a sacrocolpopexy? -- involving Prolift®? 19 19 Q. 20 A. Okay. Now I understand your 20 A. 21 21 And what did that study show with question. Q. 22 That depends on what you're 22 regard to primary end point? doing at the time of sacrocolpopexy. A. I'd have to get the paper out and 23 23 24 Q. 24 review it. 25 The way I do it and those 25 Q. Did you discuss the Withagen A.

_	Page 241	_		Page 242
1	paper in your report?	1	Do you know if that study was	
2	A. Yes, I did.	2	adequately powered?	
3	Q. Can you just point to me where?	3	A. I'd have to look at it to	
4	A. Well, it will be in here Page	4	determine that.	
5	38 under the subsection "Anatomic Results,"	5	Q. Do you know what the rate of mesh	
6	the very top line, first paragraph,	6	exposure was with the Prolift® arm?	
7	Reference Number 40 discusses her paper.	7	A. I I would have to look again	
8	And it's referencing anatomic superiority	8	at it. Off the top of my head, it was like	
9	over traditional repair, which there was	9	15, 17 percent, something like that, and	
10	none in the paper.	10	then the study was terminated prior to	
11	Q. I'm sorry. Say that again?	11	significant enrollment.	
12	A. Specifically, and then reading	12	Q. Do you recall what the rate of	
13	directly out of my document, Page 30,	13	suture erosion was in the other arm?	
14	transvaginal mesh posterior and transvaginal	14	A. No, I do not. I'd have to look	
15	mesh apical POP repairs did not produce any	15	at the manuscript.	
16	it says, provide any anatomic superior	16	Q. Do you know if the authors	
17	results benefit compared to traditional	17	reported a statistically significant	
18	transvaginal non-mesh POP procedures,	18	difference in the rate of mesh exposure	
19	Reference 40, which that is one of them,	19	versus suture erosion in the two arms?	
20	Withagen. There's three others in there	20	A. Again, I'd have to look at the	
21	that I reference.	21	manuscript to determine that.	
22	Q. The Inglesia study you referenced	22	Q. Page 9.	
23	in your	23	A. Okay.	
24 25	A. Yes.	24 25	Q. Back to Paragraph 5, we were	
25	Q report.	23	talking about.	
	Page 243			Page 244
1	Page 243 A. Okay.	1	BY MR. SNELL:	Page 244
1 2		1 2		Page 244
	A. Okay.		BY MR. SNELL:	Page 244
2	<ul><li>A. Okay.</li><li>Q. You mentioned there's the risk of</li></ul>	2	BY MR. SNELL: Q. Would you agree that there's a	Page 244
2 3	A. Okay. Q. You mentioned there's the risk of serious injury.	2	BY MR. SNELL: Q. Would you agree that there's a risk of serious injury with colporrhaphy?	Page 244
2 3 4 5 6	<ul><li>A. Okay.</li><li>Q. You mentioned there's the risk of serious injury.</li><li>A. Yes.</li></ul>	2 3 4	BY MR. SNELL: Q. Would you agree that there's a risk of serious injury with colporrhaphy? A. Yes.	Page 244
2 3 4 5 6 7	<ul> <li>A. Okay.</li> <li>Q. You mentioned there's the risk of serious injury.</li> <li>A. Yes.</li> <li>Q. Do you see that in Paragraph 5?</li> <li>A. Yes, I do.</li> <li>Q. Would you agree that there's a</li> </ul>	2 3 4 5 6 7	BY MR. SNELL: Q. Would you agree that there's a risk of serious injury with colporrhaphy? A. Yes. Q. In the next paragraph, B-1 A. Number 1? Yes. Q. Yes. On Page 9 of your report.	Page 244
2 3 4 5 6 7 8	<ul> <li>A. Okay.</li> <li>Q. You mentioned there's the risk of serious injury.</li> <li>A. Yes.</li> <li>Q. Do you see that in Paragraph 5?</li> <li>A. Yes, I do.</li> <li>Q. Would you agree that there's a potential risk of serious injury with the</li> </ul>	2 3 4 5 6 7 8	BY MR. SNELL: Q. Would you agree that there's a risk of serious injury with colporrhaphy? A. Yes. Q. In the next paragraph, B-1 A. Number 1? Yes. Q. Yes. On Page 9 of your report. A. Yes, I'm looking at it.	Page 244
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2 3 4 5 6 7 8 9 10 11 12 13	A. Okay. Q. You mentioned there's the risk of serious injury. A. Yes. Q. Do you see that in Paragraph 5? A. Yes, I do. Q. Would you agree that there's a potential risk of serious injury with the sacrocolpopexy? A. Yes. Q. Would you agree there's a potential risk of serious injury with the sacrospinous ligament fixation?	2 3 4 5 6 7 8 9 10 11 12 13	BY MR. SNELL: Q. Would you agree that there's a risk of serious injury with colporrhaphy? A. Yes. Q. In the next paragraph, B-1 A. Number 1? Yes. Q. Yes. On Page 9 of your report. A. Yes, I'm looking at it. Q. You say, Synthetic transvaginal meshes for POP, including Prolift®subject patients to needless danger through increased risks not present in traditional, non-mesh surgery."	Page 244
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Page 245 Page 246 1 would be all inclusive. 1 O. Okay. 2 Q. And what increased risks do you 2 And then I -- foreign body 3 3 reaction, increased foreign body reaction, believe are attendant with the Prolift® 4 4 degradation, pain syndrome, sexual function, system as compared to traditional, non-mesh 5 5 surgery? dysfunction. 6 6 Q. And is it your opinion that these A. Again, I outlined that in the 7 expert report very thoroughly, which we can 7 potential risks are increased with Prolift® 8 go through that complications section. 8 compared to the traditional surgical 9 O. Okav. 9 repairs? A. Yes. 10 Α. Go through each one. It -- it's 10 11 on Page 5 of the Table of Contents. I go 11 Q. Are they statistically through the safety, which then starts on 12 12 significantly increased? Page 42 or so. Actually, on Page 41 is the A. I can't speak to statistically 13 13 introduction and then we have it all -- all significant. We'd have to go to study by 14 14 the subsets of impaired vaginal healing, 15 15 study. contiguous organ injury, voiding Q. Have you done that? Have you 16 16 dysfunction, contraction. 17 17 done that? 18 Q. I'm sorry. Where are you at, 18 A. I have looked at the frequency of it looking at the TVM studies, the Hinoul 19 Doctor? 19 20 A. Oh, I'm sorry. I'm just reading 20 study, the various different French group 21 off of the Table of Contents beginning in --21 studies and looked at them. the text itself begins on Page 41 and then 22 22 Q. Have you compared them I'm just reading the points because you statistically, though, to see if there's any 23 23 24 asked what was increased and so that's what 24 statistically significant difference? Well, there's the randomized, 25 I was going through. 25 Page 247 Page 248 controlled studies by Withagen, who compares 1 Well, that's a rough, 1 2 the erosion rates versus the non-mesh groups 2 across-the-board statement. It's pretty 3 showing what, 16.9 percent erosion, 3 much -- in many of the literature, it's 4 something like that, I might not be exact, 4 roughly that number. 5 which is statistically significant over the 5 Q. With regard to Prolift®, is it 6 other groups. 6 your opinion that approximately 50 percent 7 7 of mesh exposures can be treated And then we also have to 8 8 compare in there, you can't compare apples conservatively? 9 to apples because you have like, again, the 9 A. Correct. And the other 50 10 severity of the problem. Suture erosion 10 percent require surgical exploration. versus mesh erosion are two completely Q. And the conservative ways of 11 11 treating a mesh exposure with Prolift® would 12 separate problems. 12 Q. In the cohort of mesh exposures include just watching it and doing nothing; 13 13 in Withagen do you happen to remember how 14 14 correct? 15 many of those were conservatively treated 15 A. Yes. with just either watchful waiting or Q. You can use the topical 16 16 application of estrogen; correct? 17 estrogen cream? 17 18 A. I would have to look at the study 18 A. Yes. As long as there's not a to get the specific number. By and large, 19 19 contraindication. 20 it's roughly 50 percent could be treated 20 Q. Any other conservative way of 21 conservatively, 50 percent require surgical 21 treating mesh exposure with Prolift®? 22 re-operation. 22 A. I believe those are the two big Q. So it's your opinion that 50 23 23 ones. percent of women who have mesh exposures can And of the 50 percent of patients 24 24 25 be treated conservatively? 25 who you believe with Prolift® have to have

Page 249 Page 250 some type of surgical intervention for their A. I don't believe there's an 1 1 2 mesh exposure, a majority of them are able 2 accurate number out there because we don't 3 to have the mesh excised and treated on one 3 know the denominator in the situation. 4 4 occasion, according to the literature; O. In some patients who need 5 5 excision for a mesh exposure is it correct correct? 6 6 that the surgeon can in 10 or 15 minutes A. I'd have to look at the 7 literature. I don't know off the top of my 7 perform an excision and resuture of that 8 8 head the percentage that one treatment. mesh exposure? 9 9 Probably many can, but I don't know of the MR. ANDERSON: Objection. 10 exact number. 10 Go ahead. 11 Q. Have you seen any studies on 11 THE WITNESS: It depends upon Prolift® that demonstrate that a high number 12 12 the magnitude of the erosion. So to answer of the patients with mesh exposure who need your question, if it were a very small 13 13 an intervention have to undergo multiple erosion, that possibly could be done. If 14 14 mesh revisions? it's a large erosion, it can't be done. 15 15 A. I've seen a significant number BY MR. SNELL: 16 16 and taken care of them myself in my own O. If it's a mesh exposure of two to 17 17 18 practice where one treatment does not do it 18 three millimeters, would you agree that in and they require multiple treatments. those types of mesh exposures a surgeon can 19 19 20 Q. In the literature is there a 20 go in, excise that exposure and re-suture it 21 number that you are aware of that you think 21 within 10 to 15 minutes? 22 accurately describes the number of Prolift® 22 A. Too many variables in that: The mesh exposure patients who need more than 23 23 patient, her degree of pain, if there's a 24 one surgical procedure to excise that mesh 24 concurrent infection. If any of those are present, you would not be able to do that. 25 exposure? 25 Page 251 Page 252 If all of those are excluded, then you might 1 Q. Correct, you do not recall it. 1 2 2 I do not recall it, yes. be able to. So I can't give you a 3 definitive answer because, again, there's 3 Q. The majority of mesh exposures 4 that you have treated for prolapse surgeries too many variables. 4 5 Q. How many Prolift® mesh exposures 5 involved Apogee®, Perigee® and the Elevate® 6 have you treated? 6 products; correct? 7 7 A. I wouldn't be able to break it That is correct. Α. 8 8 down because I have not looked at How many, in combination, 9 specifically Prolift®. 9 Apogee®, Perigee® and Elevate® mesh 10 In my practice, the majority 10 exposures have you treated? are Apogee®, Perigee®, Elevate®. I think A. I'm going to give you a rough 11 11 that's just because of the regional 12 12 number: 15 to 20. differences of where they're implanted. I 13 13 MR. ANDERSON: Can I just get a know I've taken care of at least -- well, 14 14 clarification? 15 let me back up. Well, I cannot recall a 15 By exposures are we including erosions, extrusions? Prolift® exposure. 16 16 Q. So as you sit here today in your 17 MR. SNELL: That's a good --17 18 deposition, you cannot recall ever treating 18 MR. ANDERSON: Because a Prolift® mesh exposure; correct? 19 sometimes you're saying "exposure" and he's 19 20 A. I cannot recall. It doesn't mean 20 answering with "erosion." I just want to 21 it didn't happen, but I cannot recall it. 21 make sure that the record is clear on what 22 Q. But the answer to my question is 22 we're all talking about. 23 23 correct. Is that fair? 24 MR. ANDERSON: Well --24 THE WITNESS: Absolutely. 25 25 BY MR. SNELL: Yeah.

Page 253 Page 254 BY MR. SNELL: defined how you consider erosion? 1 1 2 Q. So, Doctor, when I'm talking 2 A. I've had to deal with roughly 15 3 about mesh exposures, are we communicating, 3 or 20 mesh erosions, which that's what's 4 were you talking about the same thing --4 more commonly sent to me as opposed to the 5 5 gynecologists at our institution. Which Yeah. Α. 6 6 ones were Prolift® versus the other ones, I Q. -- or are you talking about 7 something totally different? 7 just can't recall because I didn't keep 8 A. For the record, let's put it 8 track of that. down, when I hear "erosion," that means 9 9 O. Would it be accurate that the perforation into an organ. Bladder is what 10 10 majority of mesh erosions that you have 11 I usually see, that's what usually gets sent 11 treated have been Apogee®, Perigee® or to me, and urethra. Exposure and extrusion 12 12 Elevate®? are essentially going to be synonyms to me. 13 13 A. I can't say that because, again, Yeah. What I was talking about I don't -- I don't know --14 14 is mesh exposure, and I think you and I were 15 15 Q. Okay. on the same page. -- which ones. 16 16 Α. A. I believe so, yes. And that In the 15 to 20 cases of mesh 17 17 18 would -- the answer would be roughly 20 18 erosion that you have treated, were the 19 vaginal exposures. 19 majority of them where the mesh eroded into 20 Q. And then the same holds true, as 20 the bladder? you sit here today, you cannot recall ever 21 Bladder, correct. And then one 21 Α. treating a Prolift® mesh exposure; correct? 22 22 -- two that I can think of were urethral. 23 A. I cannot, no. 23 Now, when we're talking 15 to 20 24 Now mesh erosion. Have you ever 24 mesh erosions, are you talking just prolapse treated a Prolift® mesh erosion, as you have or are you including urinary incontinence 25 25 Page 255 Page 256 meshes in there too? 1 in the urethra. I would have to review the 1 2 2 A. I'm including both. database as far as what was causing what, 3 Q. Of the 15 to 20 mesh erosions, do 3 but I don't have those records. So that's 4 you know how many were for urinary why a lot of this is I'm, you know, 4 5 incontinence meshes versus prolapse mesh? 5 quesstimating over five, six, seven years. 6 A. The majority probably would be 6 Q. Uh-huh. 7 7 So that's why there's going to be for incontinence. 8 8 Q. How many prolapse mesh erosions a little bit of difficulty. 9 have you treated? 9 Q. Well, is it your best estimate 10 We're talking ten or so. 10 that you've treated less than ten mesh Α. 11 Now I'm confused. You said erosions specific for prolapse mesh? 11 you've treated 15 to 20 mesh erosions, which I would say it's accurate. 12 12 included prolapse and urinary incontinence; O. And you've treated less than ten 13 13 14 mesh erosions specific to prolapse mesh over correct? 14 15 A. Yes. 15 the last five to six years; correct? And you also testified the In the guess, yes. 16 16 majority of those were urinary incontinence; Q. And for the prolapse mesh 17 17 18 correct? 18 erosions, how did you go about treating Okay. Yes. Yes. those, the revisions? 19 A. 19 20 20 A. If there is an isolated piece So --Q. within the bladder and where it is very easy 21 Well, it gets confusing because I 21 don't keep a record. 22 22 to get to, we will attempt to do, use a I can tell you I have had nine laser on it to resect it to avoid the 23 23 where we've done laser resections of, using morbidity of an open surgery. If it is a 24 24 25 Holmium laser when they're in the bladder or 25 large area of erosion, then we'd have to do

Page 257 Page 258 1 that open. 1 out all the mesh? 2 Q. So in your practice you attempt 2 Take out, explant the entire 3 3 to treat both mesh exposure and mesh erosion mesh? 4 in the most conservative manner first. 4 Q. Yes. 5 5 Α. Absolutely. A. I would not be of that opinion. 6 6 Q. Are you of the opinion that every That is a very, very difficult surgery, very 7 case of mesh exposure, regardless how --7 morbid surgery. So no. My opinion -- and 8 8 this may vary from others -- you have to do strike that. 9 9 the -- attempt the most conservative first. There are some cases of mesh 10 exposure that are actually asymptomatic; 10 Q. That makes sense; right? 11 correct? 11 Doctor, if you can treat it with estrogen cream, why not treat it that 12 A. Well, I assume so. If they're 12 asymptomatic, we might not be seeing the way as opposed to doing surgery on it; 13 13 correct? patient, so I don't know. Yes. 14 14 Q. You've seen it described in the 15 15 A. Yes. The individuals I'm seeing literature in clinical studies involving 16 16 have already been treated with estrogen and Prolift® and other prolapse meshes that it's failed, so very rarely am I seeing 17 17 18 there are mesh exposures which are 18 those individuals. asymptomatic and, as described, that means 19 19 But for an individual who Ο. 20 the patient doesn't complain of it, it is 20 presents with a mesh exposure and it's the 21 detected upon vaginal examination; correct? 21 first-time presentation, you would agree that conservative treatment is the best 22 Α. Yes. 22 23 And are you of the opinion that 23 option. Ο. 24 regardless of how small the mesh exposure 24 Not necessarily. It depends upon is, a surgeon should seek to go in and take 25 25 the size of the erosion. Page 259 Page 260 Q. I didn't say erosion. Did I say 1 square, we are now into the larger realm. 1 2 2 erosion? I thought I said exposure. And then certainly two centimeters square. A. Okay. Yeah. That's -- yes. I Q. So this, what I've drawn, is this 3 3 heard "exposure," I said "erosion." 4 4 something you would consider a large 5 exposure? Q. Let's just back up. 5 6 For an individual who presents 6 A. I would consider that larger 7 7 with a mesh exposure for the first time you because that's not the entire area of the would agree conservative treatment is the 8 8 problem because underneath that bacteria has 9 best option; correct? 9 gotten into the mesh. 10 A. And then what I'd say is it 10 So if you start exposing that, 11 depends upon the size of the exposure, if you're going to have denuded, devascularized 11 there is pelvic infection going on or not. vaginal mucosa. So a one-centimeter 12 12 So large exposures, painful exposure, one-centimeter-square exposure, 13 13 14 patient, obvious induration of the tissues, visually corresponds to possibly two or 14 15 then estrogen may not be advisable. Small 15 three centimeters of underlying degraded exposures, otherwise healthy, minimally tissue and mesh. So that's what I'm saying 16 16 symptomatic, then yes, estrogen replacement. 17 is you can't -- that's the tip of the 17 18 Q. If it's a smaller -- let's take 18 iceberg is the best analogy. large exposures out of the picture. 19 O. Well, is that the case in all 19 20 How do you -- well, how do you 20 cases -- in all cases of one-centimeter define large exposures? Do you have a exposures, is it your opinion that two to 21 21 benchmark? More than 10 millimeters, 20 three centimeters of tissue below that are 22 22 23 23 compromised? millimeters? 24 A. No. I would say in my practice, 24 Α. No. 25 if we're talking greater than one centimeter 25 Are you aware that one-centimeter Q.

Page 261 Page 262 Okay. 1 exposures have been able to have been 1 Q. 2 treated conservatively without surgery? 2 I'm saying we have to think about 3 A. I'm also aware of --3 all of the options when we see somebody. 4 4 Q. What percent of your mesh That's a yes or no answer. Give O. 5 5 me the answer and then we can talk about exposure cases had concomitant infection? 6 what you're also aware of. 6 A. We never cultured them so I 7 Is that correct? 7 cannot say on that. When you look at the 8 8 mesh and there's granulation tissue and the A. Yes. Yes. mesh is exposed, that is a colonized mesh. 9 Q. All right. What were you about 9 to say you're also aware of? That, by very strict definition, is an 10 10 11 A. Okay. What -- you have to look 11 infected mesh. The severity of the at each individual differently. Again, the 12 12 infection may be mild. pain tolerance, the anxiety level of the O. So you never cultured any of 13 13 patient, those factors, also, the vaginal these mesh exposures for different types of 14 14 15 exam. 15 organisms --Α. 16 You are absolutely correct, an 16 No. 17 isolated, small, one centimeter, where the O. -- to see the count of pathogenic 17 18 tissue is growing through the mesh and you 18 versus non-pathogenic bacteria? can just barely feel it is one thing versus A. It will be all contaminated. If 19 19 20 another one where you can look at it, 20 we put a probe into the vagina, it's going to be contaminated because we don't know 21 there's a foul smell, the patient is very 21 uncomfortable when you touch it, and you get 22 22 what to do with those kinds of results. the impression this is a bigger situation. 23 23 I have done it where there's 24 So you cannot go off of just a 24 tracking. Just last week, there was tracking going up the -- toward the one-centimeter-square rule. 25 25 Page 263 Page 264 obturator foramen, where you could actually 1 infections; correct? 1 2 put your finger in a full digit's worth. 2 No. They've been afebrile. 3 That I cultured. I don't know what the 3 Q. And they haven't had elevated 4 results are on it because I'm not back home. 4 fevers; correct? 5 So, again, there can be no 5 A. That's what afebrile is. Yeah. 6 absolutes. Case-by-case situation. 6 No. No, they have not had an elevated 7 O. Well, in those cases of mesh 7 temperature. 8 exposure you treated, how many of them had 8 Q. Now, for the mesh erosion cases, 9 concomitant elevations of white blood 9 you've said if there was an isolated piece 10 10 of mesh in the bladder, you would use a counts? 11 A. We don't routinely check a CBC laser to resect the mesh? 11 12 unless they're going to the operating room. 12 That would be one of the options. Q. Well, I thought you said that by 13 13 They'd have to be -- so we would attempt to the time, when they got to you, the majority do that if the mesh were in an ideal 14 14 15 of them, you were doing some type of mesh 15 location, we could get to it, and it appeared that we could easily resect it. 16 excision. 16 17 A. Yes. And then the CBC, And that is an evolving study. 17 18 specifically the white count, is not 18 At this point, we have nine patients that necessarily part of the routine evaluation. we've done that in, and we are going to be 19 19 20 White count is only going to be elevated if 20 attempting to publish that data or present we're talking about a systemic type of that data to AUA in 2013. 21 21 22 infection. These individuals that I have 22 O. That is a more conservative way dealt with have not had systemic infections. of treating the mesh erosion, in your 23 23 Q. So on the mesh exposure cases 24 24 opinion; correct? 25 you've treated they have not had systemic 25 A. Correct. Yes.

Page 265 Page 266 1 Than the open surgery; correct? 1 transabdominally. 2 That's correct. I have done the 2 Q. Are you aware of surgeons who --3 open surgery. It is very difficult. And 3 strike that. 4 I'm not necessarily convinced that we can 4 Are you aware of surgeons who 5 5 adequately solve the problem with that. So treat mesh erosions transvaginally? 6 I try -- my goal is to try as conservative 6 A. I am not aware of that. The 7 as possible. 7 treatment as far as dealing with this --8 O. What type of open surgery are we 8 just like the nomenclature of the problem is 9 talking about? 9 evolving, I am by no means stating that the way I do it is the absolute correct way. We 10 Α. Transabdominal. 10 11 So you make a transabdominal 11 are all figuring this thing out, and that's Q. why the attendance at meetings in national, 12 incision so you can get to and visualize the 12 international are key to talk about this. 13 bladder --13 So is it correct that as you sit 14 A. Yeah. 14 here today, you do not know how to treat a 15 Q. -- see if there's a mesh 15 mesh erosion transvaginally? 16 exposure, mesh erosion to the bladder? 16 No. I know how to -- I could do 17 A. Yeah. Mesh exposure to the 17 18 bladder or if there's banding also. But 18 it. I'm -- I can take care of vesicovaginal yes, because we can't -- to do it 19 19 fistulas transvaginally. I'm prepared to do 20 transvaginally you -- the tissues are 20 that. densely adherent to this mesh. 21 21 I don't know of the ones that I 22 Transvaginally, I don't know a way of being 22 have seen that I would be able to get the able to do that without creating a bigger mesh out and get the bladder healthy, trim 23 23 24 hole and creating a vesicovaginal fistula, 24 off the ischemic or infected sections, close 25 so that's why we attempt it 25 that without injury to the ureteral orifices Page 267 Page 268 was a mesh erosion for prolapse surgery that and then subsequently close the bladder --1 1 2 close the vagina and hope it's going to 2 you treated -- strike that. work. If somebody can do it, great. I'd 3 3 For one of these mesh erosion 4 like to see that study and video and surgeries that you've performed regarding 4 5 follow-up. 5 prolapse did you attempt to remove all the 6 Q. In the mesh erosion cases that 6 mesh in every case or did you start more 7 7 you've had -- strike that. conservatively and kind of handle things as 8 8 In the mesh erosion cases you they came? 9 have had involving prolapse mesh for which 9 A. I -- first of all, I think it is 10 10 next to impossible to remove all of the you --11 Prolapse. Okay. Yes. I'm mesh, with the arms, to -- to burrow it out Α. 11 12 12 of the muscles. Physically, that is very, sorry. very difficult. 13 Q. SUI on the side. 13 14 In comparison, a recent case of 14 Α. Yeah. 15 For the mesh erosion cases you 15 a TVT® erosion, it was horribly difficult, where we used big scissors to chomp the have dealt with involving prolapse mesh for 16 16 which we agreed that it's likely less than thing out. And those are easy, compared to 17 17 18 ten -- correct? 18 pelvic organ prolapse meshes. So no, my goal is not to go and get rid of all the 19 Α. That is correct. 19 20 Q. How many of those patients had 20 mesh. My goal is to go in there and to remove what problem can be easily done. 21 systemic infections? 21 And the reason is not because 22 A. None of them had clinical 22 evidence of fever to suspect that. They had I'm afraid of the work, it's that I'm 23 23 localized discomfort and discharge. concerned that I might not solve the 24 24 25 O. And if there was a -- if there 25 problem, I might create more issues in

Page 269 Page 270 trying to deal with it. And that's my do as little as possible. But I have been 1 1 2 personal technique. Others at my 2 burned doing that, also. 3 institution have a different approach. 3 Q. So if there's a small mesh 4 Q. Mesh erosions from prolapse can 4 erosion, your goal is to do as little as 5 5 come in different sizes; correct? possible for treating that mesh erosion for 6 6 prolapse; correct? Α. Yes. 7 Q. Different degrees of severity; 7 A. Again, looking at the patient in 8 8 the totality, what all is she describing? correct? 9 If she's only describing voiding issues, 9 A. Yes. dysuria, those types of things, then, yes, 10 O. And if you had a small mesh 10 11 erosion from a prolapse mesh, you wouldn't 11 as little as possible. If she is describing need to remove all the mesh that had been intense pelvic pain and on pelvic exam I can 12 12 put in in the first place; correct? feel banding or folding, then I will do 13 13 Again, you have to look at the more, maybe. It's patient by patient. 14 14 totality of the patient, what all they're Q. It depends upon how the patient 15 15 presents and her symptomatology; correct? 16 describing. 16 That is -- that is a fair 17 My philosophy, which is 17 18 specifically me, is try and do as little as 18 statement, yes. possible because the mesh in the belly is a 19 19 Q. And so for mesh erosion cases 20 viper. You start opening it up, you expose 20 involving prolapse you're not of the opinion 21 more of it, spill urine on it, and you might 21 that the mesh needs to be taken out in every be creating more of an inflammatory 22 22 case; correct? 23 response. 23 A. That is my personal opinion. 24 So to answer your question, if 24 And, again, this is evolving. I don't know 25 there's a small mesh erosion, my goal is to if the -- the right answer is known yet. 25 Page 271 Page 272 But that is my personal opinion, yes. 1 mean, they're too numerous to count. I 1 2 O. What type of laser are you using 2 don't know. for these resections on the more Q. When was the first case of mesh 3 3 4 conservative way of treating mesh erosion? 4 contraction that you treated from a prolapse 5 A. Holmium, H-O-L-I-U-M. 5 mesh? 6 Q. Is that the brand name or is that 6 A. Good guestion. I don't know. It 7 7 slowly started, like a snowball or whatever the actual type of beam? 8 A. No. That's the actual beam. I 8 that rolling down the hill, whatever that 9 don't know what company makes it. 9 thing is called. I have no idea to give you 10 Q. How many cases of mesh 10 a fair estimate or when that began. Because 11 contraction -it wasn't really registering. It was an 11 isolated problem that became more and more 12 Too --12 Α. -- have you treated? 13 13 frequent. Too numerous to count. I don't Q. As you sit here today, you're not 14 14 15 know. I don't keep track. I mean, but 15 able to tell me when you first began -- when contraction and pain and banding all in the you first treated a mesh contraction case 16 16 same category, and I will not even be able 17 for Prolift®. 17 18 to give you an estimate. 18 A. No, I --Well, I can tell you an 19 19 MR. ANDERSON: Objection. 20 example. The Friday before I talked to Adam 20 MR. SNELL: Strike that. That Slater, November 2nd, I believe, I saw five. 21 21 was a bad question. I got my words mixed And the numbers are increasing from... 22 22 up. 23 Q. How many cases of mesh 23 BY MR. SNELL: contraction have you seen for prolapse mesh? 24 24 Q. As you sit here today, is it 25 A. That's what I'm talking about. I 25 correct that you cannot tell me when you

Page 273 Page 274 Dr. Kirkemo was still alive. 1 first treated a case of mesh contraction 1 2 from prolapse mesh? 2 BY MR. SNELL: 3 3 A. I --Q. So you're talking about Dr. Aaron 4 MR. ANDERSON: Asked and 4 Kirkemo? 5 5 A. Correct. Yes. answered. 6 6 Q. Do you know Dr. Aaron Kirkemo? Go ahead. 7 THE WITNESS: I can tell you 7 A. I have only encountered him 8 the first that I remember, which is not the 8 briefly at the Minnesota Urological 9 Association meeting. I'd have to look -- I first case. The first case that I remember. 9 don't know if it's in my CV or not -- we 10 MR. SNELL: Okay. 10 11 THE WITNESS: 2009. It was a 11 gave a talk or sacrocolpopexy, my resident did, Dr. Igor Frank, not that that's --12 patient from Minneapolis who came down to me 12 that's not pertinent. who had a Prolift® by Dr. Kirkemo. 13 13 14 MR. SNELL: Okay. 14 And we made the comment that THE WITNESS: And I can 15 the robotic -- the sacrocolpopexy itself 15 puts the vagina in a more normal access, 16 remember it very clearly because I asked, 16 who did your surgery and she said which is pretty much an undisputed comment 17 17 18 Dr. Kirkemo, who I knew of his name. And 18 or conclusion. she says he had died. And he says, "I disagree. I 19 19 20 And so I hadn't heard that so 20 think sacrospinous fixation is more normal." And I said, "No, there's no 21 that's why I remembered it. And that was 21 data to support that. It puts it off to the 22 for pelvic pain. On exam, there was 22 contraction and banding. And I didn't think right angle." And that was it. 23 23 24 anything more of it beyond that until I got 24 And so that was in 2003, 2004, 25 involved in this and I realized that 25 around that time. So that's -- that's my Page 275 Page 276 only interaction that I know of as 1 A. Yeah. And I wouldn't say I was 1 2 encountering him, until that one patient. 2 necessarily speaking to him. I was speaking And that was not directly with him. to the audience, addressing his comment, 3 3 which I didn't think was accurate, based 4 Q. And so you were talking about 4 5 5 sacrospinous ligament fixation that's upon the medical literature. 6 performed where the vagina is moved over to 6 Q. Was he talking about the 7 7 anchor it towards one side of the unilateral sacrospinous ligament fixation --8 8 sacrospinous ligament. Yeah. Α. 9 Correct. Usually the right side, 9 Q. -- or the bilateral attachment? 10 just because the surgeons are, the majority, 10 Unilateral. I believe 11 right-handed. unilateral. I can't recall it specifically. 11 O. As opposed to the other technique What about Dr. Dennis Miller; do 12 12 where it is actually attached to both you know him? 13 13 14 sacrospinous ligaments. No, I do not. 14 Α. Dr. Piet Hinoul, do you know him? 15 A. Correct. Yes. Which is done 15 Q. sometimes. But this one happened to be No. Never met him, either of 16 16 Α. 17 because he was talking off of the right 17 those. 18 side. 18 Q. Dr. Charlotte Owens, do you Q. Were you trained on -- what's 19 19 know --20 that approach for the sacrospinous ligament 20 A. No, never met her. where it's attached to both sides? Do you know anyone from Ethicon, 21 21 besides this interaction you had with 22 A. Yeah, I know what you're 22 23 referring to, and no, I was not. Dr. Kirkemo, who subsequently was there? 23 Q. That's the only time you've ever A. Yeah. To the best of my 24 24 25 spoken to or seen Dr. Kirkemo? 25 knowledge, only Dr. Kirkemo, which, again,

Page 277 Page 278 is brief. Dr. Robinson I believe was in months, because I saw her back, and what we 1 1 2 Kansas City or something like that, so I've 2 -- we initially had success and then the 3 given talks in Kansas, I believe. I don't 3 pain came, returned. 4 recall exactly. So, I mean, I could have --4 Q. The first case that you talked 5 5 about of mesh contraction, were you I don't know him. 6 Q. You don't have any specific 6 successful in treating that? 7 recollection of knowing him, of talking 7 A. No. 8 8 with --O. What was the course of that? 9 A. None. Absolutely not. 9 A. Well, if you're referring to that 10 Q. -- Dave Robinson or --10 Prolift® Kirkemo patient --11 A. Absolutely none. 11 Yes. Q. 12 Q. Other than the one case of 12 A. -- no, I was not. It was diffuse 13 Prolift® mesh contraction, are you aware of 13 pelvic pain. any other mesh contraction cases you've 14 14 The majority of what I see, dealt with that concerned Prolift®? like those five patients just recently, is 15 15 this diffuse pelvic pain, which I don't have 16 A. Yeah. One recently where there 16 was banding deep into the vagina. You could any treatment for. 17 17 18 feel a -- a 52-or-so-year-old woman, it was 18 Q. Do you refer them to anyone who actually done in the same group, has treatment modalities? 19 19 20 Dr. Kirkemo's old group, which I get a fair 20 A. Yes. Either our -- our pain bit of business from, and a very specific 21 21 clinic, sometimes our physical medicine and band and severe dyspareunia. rehab, which deals with pelvic floor 22 22 myalgia, or Dr. Antolak is close, and I will 23 O. Was that a more recent case? 23 24 Yes. In the past -- actually --24 send it to him. actually, it's been probably about three 25 25 Q. What's Dr. Antolak's first name? Page 279 Page 280 A. Stanley. 1 treating pain syndromes; correct? 1 2 2 What type of doctor is he? A. Well, they don't have a pelvic O. 3 He -- well, he's a urologist and 3 pain clinic, that I'm aware of. They have a he was at Mayo and specializes in pelvic 4 4 pain clinic. 5 pain, and then he retired and then restarted 5 I thought that's what I said. 6 practice up in the Minneapolis area. So if 6 A. You said --7 you -- if you -- just so we're clear, I do 7 O. Oh, you're right. You're right. 8 know him quite well. He is -- has given a 8 You're right. Let me rephrase it because I 9 deposition in I believe Gross's or Wicker's. 9 didn't mean to say that. 10 Okav. 10 The Mayo Pain Clinic actually Q. 11 So I do know -- I have not collects data on how successful they are in Α. 11 the outcomes of things such as lessening 12 personally spoken with him in four or five 12 years but I do know him quite well from my 13 13 patients' pain; correct? A. I -- I -- not to be difficult, I 14 work at Mayo. 14 15 Q. And you say he used to be at Mayo 15 have no idea if they do or not. but now he's where? Q. Would it surprise you that over 16 16 A. Minneapolis area. And he runs 75 percent of the patients treated at the 17 17 the -- I think it's called the Midwest 18 18 Mayo Pain clinic report improvements in Pelvic Pain Clinic or something like that. their pain symptomatology? 19 19 20 It's -- it's some variant of that. And so 20 A. Yeah. Improvement doesn't mean a if the patient is from the Minneapolis area 21 21 whole lot to me because improvement could be 22 and there's nothing I can do, frequently, 22 pain going from a seven to a six, I'll send it to him. statistically improved, significant but 23 23 clinically not significant. 24 Q. Mayo Pelvic Pain Clinic actually 24 25 collects data on how successful they are in 25 Q. So as you sit here today, do you

	Page 281			Page 282
1	know whether Mayo Clinic's Pain Clinic	1	<ul> <li>A. If they have banding in the</li> </ul>	
2	offers treatment for patients which is	2	vagina where I can actually palpate it, I	
3	statistically significant but not clinically	3	touch it and the woman literally screams,	
4	significant?	4	then I don't believe any physical therapy is	
5	A. No, that's not what I said. I'm	5	going to be resolving that. If they have	
6	just saying improvement in pain is good, but	6	diffuse pelvic discomfort with movement,	
7	is it good enough? And I don't know. I	7	doing anything, then, by all means, you're	
8	have not seen or talked to anybody in the	8	right, I send them to the pain clinic, if	
9	clinic of what their results are.	9	they can get in.	
10	Q. You haven't looked at their	10	Q. If they have banding in the	
11	Website to see what the Mayo Clinic, pain	11	vagina, you've seen it reported in the	
12	clinic, reports as their rates of success	12	literature that in many cases that can be	
13	for outcomes?	13	successfully treated by releasing the band;	
14	A. No, I have not.	14	correct?	
15	Q. When you refer your patients to	15	MR. ANDERSON: Objection.	
16	the pain clinic at the Mayo Clinic, why do	16	Go ahead.	
17	you make those referrals?	17	THE WITNESS: Yeah. Yeah.	
18	A. Because there's nothing I can do	18	That's why I do it.	
19	for them, and we're trying to help the	19	BY MR. SNELL:	
20	individual out in any way we can.	20	Q. And that's how you treat the	
21	Q. Well, would you agree that	21	cases where there is banding. You attempt	
22	actually sending them to the pain clinic	22	to go in and release that band that's in	
23	first instead of doing surgery on them is a	23	tension; correct?	
24	more conservative approach to treating their	24	A. Correct. And that is a very	
25	pain syndrome?	25	specific situation where on pelvic exam I	
	Dags 202			D= == 204
1	Page 283	1	came back and the pain is back. So it's	Page 284
1	can touch the specific area, you can feel	1	came back and the pain is back. So it's	Page 284
2	can touch the specific area, you can feel it, it's like a rope, and other places it's	2	very frustrating for everybody.	Page 284
2	can touch the specific area, you can feel it, it's like a rope, and other places it's not that way. And then I do that. I try	2	very frustrating for everybody. Q. You've had cases where there has	Page 284
2 3 4	can touch the specific area, you can feel it, it's like a rope, and other places it's not that way. And then I do that. I try and I cut it and resect as much of the	2 3 4	very frustrating for everybody.  Q. You've had cases where there has been specific banding to one area of the	
2 3 4 5	can touch the specific area, you can feel it, it's like a rope, and other places it's not that way. And then I do that. I try and I cut it and resect as much of the mesh as I can to hope to reduce that	2 3 4 5	very frustrating for everybody. Q. You've had cases where there has been specific banding to one area of the vagina and you released that band and that	
2 3 4 5 6	can touch the specific area, you can feel it, it's like a rope, and other places it's not that way. And then I do that. I try and I cut it and resect as much of the mesh as I can to hope to reduce that tension.	2 3 4 5 6	very frustrating for everybody. Q. You've had cases where there has been specific banding to one area of the vagina and you released that band and that has resulted in a positive outcome for the	
2 3 4 5 6 7	can touch the specific area, you can feel it, it's like a rope, and other places it's not that way. And then I do that. I try and I cut it and resect as much of the mesh as I can to hope to reduce that tension.  Q. So when there's a band, you cut	2 3 4 5 6 7	very frustrating for everybody.  Q. You've had cases where there has been specific banding to one area of the vagina and you released that band and that has resulted in a positive outcome for the patient; correct?	
2 3 4 5 6 7 8	can touch the specific area, you can feel it, it's like a rope, and other places it's not that way. And then I do that. I try and I cut it and resect as much of the mesh as I can to hope to reduce that tension.  Q. So when there's a band, you cut it and resect the mesh in that particular	2 3 4 5 6 7 8	very frustrating for everybody. Q. You've had cases where there has been specific banding to one area of the vagina and you released that band and that has resulted in a positive outcome for the patient; correct?  MR. ANDERSON: Objection.	
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	Page 285		Page 286
1	I would say some are improved	1	be statistically
2	and they have not come back. See, if they	2	Q. How about this? In some of your
3	don't come back, I've kind of forgotten	3	patients who have had banding in their
4	about them. So what I do is I see the ones	4	vagina for which you've gone in and released
5	who do come back, so they stick out in your	5	the band, they have come back to you and
6	mind more.	6	they have reported improvements; correct?
7	BY MR. SNELL:	7	A. No.
8	Q. So in some of your patients who	8	Q. No?
9	have had banding in the vagina you've been	9	A. They come back to me they've
10	able to release that banding and it has	10	come back to me and said, I was good for a
11	alleviated their pain	11	while and it is now back.
12	A. But	12	Q. I think I'm getting confused now.
13	Q such that they have not come	13	Patient has a band.
14	back to you; correct?	14	A. Uh-huh. Yes.
15	A. That I can't answer	15	Q. You decide I need to release that
16	MR. ANDERSON: Objection.	16	band. You do that procedure; correct?
17	Go ahead.	17	A. Yes.
18	THE WITNESS: I can't answer	18	Q. We're together.
19	that because they have not come back to me.	19	A. Yes.
20	BY MR. SNELL:	20	Q. Do you ask those patients to come
21	Q. Well, that's what I'm qualifying.	21	back for postoperative follow-up or do you
22	A. No. That may mean they've gone	22	just send them on their way?
23	to a different doctor.	23	A. We ask them well, to say to
24	Q. All right. I've got you.	24	send them on their way sounds very cruel.
25	A. So that's why I can't I can't	25	What we do is say we have treated this
	•		·
	Page 287		Page 288
1		1	Page 288 A. Correct.
1 2	Q. Okay.	1 2	A. Correct.
2	Q. Okay. A we have cut this. If you are		A. Correct. Q. And you told them, if you're
	Q. Okay.	2	A. Correct. Q. And you told them, if you're doing fine, you don't need to come back to
2 3	Q. Okay. A we have cut this. If you are if you have problems, you come back and	2	A. Correct. Q. And you told them, if you're
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Page 289 Page 290 can't travel -- if you're in the Dakotas, 1 always going to be a concern of 1 2 communication issues. 2 the Dakotas are huge states. You can be 14 3 3 hours away and still be in one of the If you have somebody who's in 4 an intense amount of pain and crying in your 4 Dakotas. And you can't make that trip back. 5 5 Q. Besides the two cases of Prolift® office, which happens on a daily basis for 6 me, they might not necessarily retain 6 mesh contraction that you've recalled, do 7 everything I say. Now, I'm quite cognizant 7 you recall any others specific to Prolift®? 8 8 of that. I don't recall any, no. 9 That's why you give them written 9 I'm not sure if I asked this, but Q. 10 referrals; correct? 10 for prolapse-specific mesh contraction was 11 That's why we -- a copy of my 11 the first case that you remember the 2009 12 notes always go to them and to their doctor 12 case? 13 back home. 13 There were --Α. That's why if you make a referral 14 14 Was that the first Prolift® O. to the Mayo Pain Clinic, sometimes you'll 15 15 prolapse cases? have the pain clinic contact the -- contact A. No. There were more before then, 16 16 the patient to see if they are going to but it's a blur. That's the 2009 one, it's 17 17 18 follow that recommendation; correct? 18 just because that happened to be very A. I can't say that because the 19 significant with Kirkemo's death, which was 19 20 problem with our pain clinic is they can be 20 not accurate. 21 out months. So if a patient is in my 21 MR. ANDERSON: Greatly office, I put an order through for it and a 22 22 exaggerated? patient is from a long ways away or has 23 23 THE WITNESS: Yeah. That's 24 family, they can't make it to it. Because 24 right. 25 it's not like a same-day service. And they 25 MR. ANDERSON: Can we take a Page 291 Page 292 break here in a couple of minutes? We've 1 actually make it into my clinic is going to 1 2 2 be in a given week probably five a week. been going for an hour and a half. 3 MR. SNELL: Oh, yeah. Yes. 3 And that's a really tough guess 4 because sometimes there's going to be a BY MR. SNELL: 4 5 Q. In the past year, can you give me 5 whole bunch and sometimes there's going to 6 an estimate as to the number of mesh 6 be none. 7 7 contraction cases you have treated for MR. SNELL: Okay. Take a 8 8 prolapse? break. 9 A. It's difficult to ascertain. The 9 (Recess, 6:06-6:19 p.m.) 10 only reason, I'm not trying to be difficult 10 BY MR. SNELL: as far as answering your question, because 11 11 Q. Ready to go? 12 in August, when that FDA report came out, I 12 Yes, sir. Α. believe it was at -- well, whenever it was. 13 13 O. You're aware that Prolene has 14 I think it was in August. been used for about half a century? 14 15 It was in August when that FDA 15 Since 1958, as I recall. announcement came out about pelvic organ Q. Have you used Prolene sutures in 16 16 prolapse meshes, and then in September when 17 17 your surgeries? 18 I had a document with Public Citizen, Ralph 18 Rarely. Yes. Α. Nader's group, read, the number of my Do you use different types of 19 19 20 consults started to rapidly rise and the 20 sutures for different surgeries? 21 telephone calls. 21 A. 22 And so I can give you an idea 22 In the 1950s, surgical meshes for of the number of telephone calls or requests hernia repairs were introduced; correct? 23 23 24 for consultation per week are roughly three 24 Α. Yes. 25 or four, maybe, per week. How many of those 25 In around the 1970s, surgical Q.

Page 293 Page 294 placed through the vagina; correct? 1 mesh was used to treat prolapse via the 1 2 abdominal sacrocolpopexy; correct? 2 A. Correct. 3 A. I don't know when it was started 3 Q. And as you opine, the vagina is a 4 4 contaminated environment. using there. And that sounds roughly the 5 5 Clean contaminated, which was right time frame. 6 Q. In the 1990s, vaginal mesh was 6 supported by the depositions of Hinoul and 7 used to treat prolapse via the transvaginal 7 Robinson and others. 8 8 route; correct? O. So it would be accurate that the 9 9 A. Mesh, transvaginal, in the 1990s. vagina is a clean contaminated environment? 10 I was unaware of that. The only ones I know 10 A. At the time of surgery it's a 11 about is the French group, and I don't know 11 clean contaminated. 12 when they started. 12 Q. Tell me what you mean by that. That means that it -- you can 13 O. So you're not aware of when the 13 French TVM group began looking at meshes to prep the vagina -- it has to be -- well, 14 14 use in the TVM study? let's back up. Let's go back to the 15 15 A. No. What I know is some of their contrast to say like an abdominal procedure 16 16 original studies and discussions, I saw one where you can place Betadine and other 17 17 18 paper in I believe 2001, 2002, talking about 18 substances, alcohol, those types of things, the hypothesis or the possibility of doing and get the bacterial count markedly down to 19 19 20 this. So when they actually began, we'd 20 as close to zero as possible for a time. have to predate that, which would be the 21 21 Orifice surgery, as we call it, whether it be mouth, ears -- maybe I 22 late '90s. 22 23 Q. One of your criticisms of the 23 shouldn't say ears, the ENT people would Prolift® is that -- and any transvaginal 24 24 probably disagree with that -- vagina or mesh for pelvic organ prolapse is that it's 25 25 rectum, bowel surgery, you can never even Page 295 Page 296 remotely get them sterile. You can just get 1 sacrocolpopexy. I don't. 1 2 them clean. You can decrease the bacterial 2 O. Do you do it at Mayo Clinic as 3 count but it's still a contaminated field. 3 standard treatment, to put this plastic 4 Q. For the abdomen, you can get the 4 covering on the body? 5 bacterial count down but not totally wipe it 5 A. No. But the hernia surgeons do 6 6 out; correct? it for the meshes. 7 A. No. You can -- I've done one 7 O. But for your sacrocolpopexies do 8 8 study as far as in artificial sphincters, you do it? 9 that's a treatment for male incontinence, 9 Α. No. 10 where we would have the patient with an 10 Q. And when you do a sacral -antibiotic scrub for several days, then we'd abdominal sacrocolpopexy, are you saying you 11 11 do a ten-minute prep, and then we'd culture put like Betadine and stuff on the stomach 12 12 the skin at the time of surgery, and the where you're going to make your incision? 13 13 14 bacterial count was essentially zero in most That's correct. There's a 14 15 individuals. 15 standard prep we do, which is a ten-minute So the bacteria will come Betadine prep, followed by waiting five or 16 16 17 six minutes, something, there's a certain back. And then you can also on the abdomen, 17 18 especially if you're using prosthetics, put 18 waiting time that my surgical team does, down -- gosh, what do you call it? There's that they have to let it dry. In the 19 19 20 a name, a plastic cover that sticks to the 20 process, that theoretically decreases the body that you cut into so that the skin is 21 21 bacterial count as much as possible. 22 not exposed at all. So you can have it be a 22 Q. Does it reduce it all the way sterile environment. down to zero? 23 23 A. I have not studied it. 24 Q. For the sacrocolpopexy? 24 25 You could do it for the 25 Have you studied for how long Α.

	Page 297		Page 298
1	that bacterial what do you call it,	1	A. No, I do not.
2	Doctor, where it brings the bacterial count	2	Q. And your sacrocolpopexies take
3	down? Bacterial reduction?	3	more than 45 minutes; correct?
4	A. Well, bacterial count.	4	A. Yes.
5	Q. Bacterial count reduction?	5	Q. They take more than 60 minutes;
6	A. I have	6	correct?
7	Q. Let me just get the question	7	A. Yes.
8 9	because I just want to make sure I'm not	8	Q. Some of your sacrocolpopexies
10	using terminology that's crazy.	9	take more than three hours; correct?
11	Do you know for how long with	10	A. The open sacrocolpopexies? They
12	the Betadine prep that you've identified that is effective in reducing the bacterial	11 12	may have. I don't recall them taking that
13	count?	13	long. Q. There's a risk of infection with
14	A. All I can correlate with that is	14	the robotic laparoscopic sacrocolpopexy as
15	studies that I've done with the artificial	15	well; correct?
16	sphincter, which is roughly a 45-minute to	16	A. It is a very, very small. In our
17	hour-long case, we compare the culture at	17	series we have never had one because the
18	the beginning and the end. There are	18	mesh is taken out of the box and immediately
19	studies out there specifically in ortho, in	19	put through the ports, never has any contact
20	ortho hip services, where they would culture	20	with the skin, has only sterile gloves on
21	the skin repeatedly. I don't know that	21	it, and it's put inside the patient. So
22	data, though.	22	unless there's any contamination from a
23	Q. Do you know data, though, for	23	bowel injury, which we've never had, the
24	prolapse surgery like the sacrocolpopexy,	24	mesh never has contact with bacteria.
25	for how long the bacterial count is reduced?	25	Q. Have you done any studies or
	,		, ,
	Page 299		Page 300
1	culturing of the mesh which shows that it	1	A. Your question as asked, I am
2	has no bacteria on it at the time when you	2	unaware of any higher incidence of systemic
3	place it in your robotic laparoscopic	3	infections.
4	sacrocolpopexy?	4	Q. Next question: What studies, if
5	A. No.	5	any, do you rely upon which show a
6	Q. The ports you make into the	6	statistically significantly higher rate of
7	lady's abdomen for the robotic laparoscopic	7	infection for Prolift® versus other forms of
8	sacrocolpopexy, those ports exist from the	8	prolapse surgery?
9	outside skin down into the peritoneal	9	A. I'll go to my Exhibit B. I have
10	cavity?	10	a section on infection; however, briefly,
11	A. Correct.	11	Number 53, de Tayrac, Letouzey
12	Q. And how do you prep those ports?	12	Q. Let me just get to you. I'm
13	A. That's with the standard Betadine	13	Sorry.
14 15	prep at the beginning of the case.	14	A. De Tayrac, Letouzey, "Basic
16	Q. And so is it fair to say you do not know how much of the bacterial count is	15 16	Science and Clinical Aspects of Mesh Infection in Pelvic Floor Reconstruction."
17	reduced for your robotic laparoscopic	17	
18	sacrocolpopexies two hours into the	18	Q. Oh. Page 53. A. Oh, I'm sorry. I'm sorry.
19	procedure?	19	Q. I was looking at Reference 53.
20	A. There's no way to prove a	20	A. Exhibit B, I believe. Yeah,
21	hypothesis that it is still at a low level.	21	Exhibit B.
22	Q. What studies, if any, do you rely	22	MR. ANDERSON: Reference 53, if
23	upon that show a higher rate of systemic	23	you look in the back.
24	infection with Prolift® as opposed to other	24	THE WITNESS: Oh, I'm sorry.
25	prolapse surgeries?	25	MR. ANDERSON: Well, what do

		ge 301		Page 302
1	you have? I say look at the back.		1	doctor?
2	THE WITNESS: The Exhibit B,		2	(The court reporter read back
3	the reference material.		3	the requested portion of the record.)
4	MR. SNELL: Okay.		4	MR. SNELL: That was actually
5	THE WITNESS: Number 53. I'm		5	not the question I wanted.
6	sorry.		6	THE WITNESS: Start over.
7	MR. SNELL: I don't know if I		7	MR. SNELL: Now that I hear it.
8	have it. Maybe I do have it.		8	BY MR. SNELL:
9	BY MR. SNELL:		9	Q. What clinical studies in humans
10	<ul><li>Q. Is this the materials list that</li></ul>		10	do you rely upon which show a statistically
11	was served in connection with your June		11	significant higher rate of infection with
12	15th, 2012, report, Doctor?		12	Prolift® versus other prolapse surgeries?
13	A. Correct.		13	A. Well, I have to go with that
14	Q. I'm having trouble putting my		14	Number 53 there.
15	hands on it.		15	Q. Number 53?
16	A. I can actually show you.		16	A. De Tayrac, talking about
17	Q. I don't want you to show me		17	
18	anything that Mr. Anderson secretly marked			infections in the pelvic reconstructions.
19	on there.		18	And you'd have to then compare it to other
20	A. No, there's nothing marked.		19	standard procedures out there.
21	Number 53 let's go back to		20	We could use Withagen's as one,
22	what the question was.		21	that randomized, control, because infections
23	Q. The question was		22	in the traditional repair are very uncommon
24	MR. SNELL: Actually, Madam		23	because you're not putting a foreign body
25	Court Reporter, can you read it back to the		24	in. Any surgery with a foreign body is
	_			
		ge 303		Page 304
1	going to be increasing the risk, whether it		1	The one patient I talk about
2	be in eye, hip, whatever. And so that de		2	that had an infection after the mesh, okay,
3	Tayrac one is one that I think was a very		3	she had a diffuse cellulitis. It was a
4	eloquently written paper on infection in the		4 5	Strep. infection. So if I relied on abscess
5	meshes.			and I said, oh, no abscess, you're not
6 7	Q. That's not a clinical study;		6 7	infected, that's incorrect.
	correct?		8	Q. So other than the Withagen paper,
8 9	A. Then Withagen.		9	you've mentioned a bacteria, you say Candida albicans?
10	Q. And it's your in Withagen was there an increased rate of abscess with		10	A. Candida albicans. It's a fungal
11	Prolift® versus the traditional arm?		11	infection. A fungus. Excuse me. Yeah,
12	A. Let's well, let's get the		12	it's a fungus located in the vagina.
13	Withagen paper out and we'll go over it.		13	Q. Is it pathogenic such that it
14	Q. I'll get that. We'll go over it.		14	causes complications?
15	tomorrow. Is that fair? I don't have it on		15	A. No. It's a normal part of the
16	me right here. I have it out in my car, but		16	normal flora. And there are papers in my
17	I have to make a copy. So Withagen.		17	supplement referring to the normal bio
18	A. That's fine.		18	excuse me the normal flora of the vagina,
19	But you're limiting it to		19	so that the vagina is has a large number
20	abscess. Multiple depositions I've read,		20	of multiple different types of bacteria that
21	they keep talking about abscess, abscess,		21	are present within it.
	uicy need taining about aboless, aboless,		22	•
				() Some of which are nathogenic
22	abscess. Those are pyogenic bacteria. Not			Q. Some of which are pathogenic,
22 23	abscess. Those are pyogenic bacteria. Not all bacteria are pyogenic. Candida albicans		23	some of which are non-pathogenic; correct?
22	abscess. Those are pyogenic bacteria. Not			

Page 305 Page 306 gets attached to the mesh put inside the 1 No. I mean, just because --1 body. It can be devastating, potentially. 2 there's bacteria on your skin. It's not 2 3 pathogenic until you cut it and it gets in 3 Q. Have you ever done any studies on 4 there. Okay. It's just there. It's a 4 Candida albicans? 5 5 colonization is the best way to say it. No. Α. 6 There are billions, literally, 6 Q. Besides the Withagen study, are 7 in the colon. It's not a problem unless you 7 you aware of any other studies upon which 8 perforate your colon. So it has to be --8 you rely that show, clinical studies, that 9 you have to look in that frame of reference. 9 show a statistically significant increased risk of infection with Prolift® versus some 10 Specifically in the vagina, 10 which the vagina is unique, is the presence 11 11 other prolapse surgery? of the Candida albicans and the other 12 12 A. Iglesia. Q. It's your opinion that there were 13 variants of the fungi. 13 So if the Candida albicans gets more infections in Iglesia than -- in the 14 14 on a mesh during transvaginal placement, Prolift® arm than the native repair arm? 15 15 what's the result, if any, from an infection A. I have to look at the --16 16 17 infection of a mesh can manifest itself in standpoint? 17 18 A. That would be a great one for the 18 multiple different ways, which one of the Ethicon to have studied. And I saw nothing own TVM surgeons talk about that possibly 19 19 20 in their documentations, no deposition of 20 infection can increase your risk for erosion. So in the Inglesia study that had 21 anybody ever considering that. 21 22 Everybody knows women can get a significant amount of erosions, which 22 yeast infections because why? Candida ultimately prompted them to stop the study. 23 23 24 albicans. But I never saw anybody take the 24 Correlating that with the TVM de Tayrac, you time to think, oh, no, what happens if this could theorize then that possibly that 25 25 Page 307 Page 308 infection led to their erosions, at least in 1 will say --1 2 2 part. Q. 3 Q. I don't really want theory. I 3 -- with scientific data to back want what you're going to testify to to a 4 4 me up, that a TVM surgeon, highly 5 5 reasonable degree of medical certainty -experienced in Prolift® and Gynemesh®, 6 A. I just --6 states in a paper that erosion can possibly 7 7 be caused by infection. -- at the time of trial. 8 8 Are you going to say that the I will then say that the vagina 9 15 percent erosions in Iglesia, all of those 9 is a clean contaminated environment. It 10 patients had concomitant infection? 10 cannot -- physically impossible to be That's not what I said. 11 sterilized. So, therefore, every time there Α. 11 is an erosion -- excuse me -- extrusion or 12 Do you believe all 15 percent --12 do you believe all of the erosion cases in 13 13 possibly erosion, contamination and 14 the Iglesia study had concomitant infection? infection can specifically be playing a 14 15 That's not what I said. 15 significant role. That's what I'll say on I'm asking what you believe. I the stand, which, according to Hinoul's, 16 16 know that's not what vou've said or that's 17 17 Hinoul --18 not how we're interpreting each other. I'm 18 MR. ANDERSON: Hinoul. asking you if you believe that. 19 THE WITNESS: -- Hinoul's 19 20 Well, I --20 deposition, he stated he knew, Ethicon knew, A. every possible complication prior to launch; 21 If you're going to come into 21 court at trial and say, those people who had therefore, they knew this was a risk. 22 22 mesh exposures in the Prolift® arm in the 23 BY MR. SNELL: 23 Iglesia study all had infections. 24 24 Q. They knew that mesh exposure was 25 A. Here's what -- exactly what I 25 a risk? Is that what you're going to come

	Page 309			Page 310
1	in and say?	1	Misstates prior testimony.	
2	A. Mesh exposure is a risk? Yes,	2	BY MR. SNELL:	
3	they knew that.	3	Q. Is that correct?	
4	Q. They knew that infection was a	4	MR. ANDERSON: Objection.	
5	potential risk. Is that what you're going	5	Misstates prior testimony.	
6	to come in and say?	6	THE WITNESS: Well, no. We can	
7	A. Yes.	7	go to Number 69 on there.	
8	Q. Who's this TVM surgeon you're	8	MR. SNELL: Okay.	
9	referring to?	9	THE WITNESS: Is that	
10	A. De Tayrac. He's Number 53 there.	10	BY MR. SNELL:	
11	Q. So you believe that de Tayrac was	11	Q. That's Falagas?	
12	one of the TVM group.	12	A. Falagas.	
13	A. No. I believe I've seen his name	13	There's Number 121, which is	
14	in some of the French studies on Gynemesh®.	14	M-A-M-Y. All of which are stating and	
15	I don't know I have not looked at, at	15	theorizing the possibilities of infections	
16	least I can't recall, all of the specific	16	and the consequences of infections, which	
17	TVM surgeons.	17	erosions are.	
18	Q. And because this surgeon said	18	Q. So 69, Falagas, and what was the	
19	that erosion can possibly be caused by	19	next one?	
20	infection, you will extrapolate that	20	A. 121, I believe, M-A-M-Y.	
21	statement by a single physician to your	21	And the other one would be	
22	opinion that every time there is an erosion,	22	general surgery in my supplemental report.	
23	contamination and infection can specifically	23	Her name I think it's a her. C-H-O-I.	
24	be playing a significant role.	24	That is general surgery looking at clean	
25	MR. ANDERSON: Objection.	25	contaminated wounds in general surgery	
	Page 311			Page 312
1	markedly increasing the risk of	1	clinical study data, clinical trial data.	Page 312
1 2		1 2	clinical study data, clinical trial data. MR. ANDERSON: Well, you	Page 312
2 3	markedly increasing the risk of complications.  So I'm I'm talking you			Page 312
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Page 313 Page 314 1 versus some other type of prolapse repair 1 cite to in your expert report and materials 2 surgery that you relied upon, with the 2 list involve the abdominal sacrocolpopexy; 3 caveat that when I say clinical trial data, 3 correct? 4 I mean data in humans from retrospective, 4 A. I'd have to look back. I don't 5 5 prospective, clinical studies and/or -- I don't -- I'm sure I would have included 6 randomized, controlled trials. 6 it in there because I'm looking at all of it 7 MR. ANDERSON: Objection. 7 but I don't recall off the top of my head. 8 Asked and answered to some extent of the 8 O. You would agree, Doctor, that in clinical studies looking at 9 ones he's already mentioned. 9 sacrocolpopexy -- and I'm talking about the 10 Go ahead. 10 11 THE WITNESS: I am physically 11 open abdominal sacrocolpopexy and incapable of thinking into a putting up all laparoscopic sacrocolpopexy. Are we 12 12 these borders and definition of data. together? 13 13 If you exclude volumes of data, 14 14 A. Yes. Is that including robotics? say, oh, no, we're not talking about de Q. I'm setting aside your robotics. 15 15 Tayrac, Letouzey, not Letouzey, the other Laparoscopic. Okay. 16 16 ones, just a specific clinical study that So you would agree that in 17 17 18 looked only at infection, by that 18 studies involving open abdominal and definition, no, I cannot. But I think that laparoscopic sacrocolpopexy, as I've defined 19 19 20 is academically, intellectually incompetent 20 it, some of those patients also have and wrong. You have to look at the totality hysterectomies at the time of the surgery; 21 21 of knowledge and not narrow it. 22 22 correct? (Discussion off the record.) 23 23 A. That is correct. 24 BY MR. SNELL: 24 Q. And you would agree that the Q. Doctor, some of the articles you vagina would be exposed to these same 25 25 Page 315 Page 316 bacterium -- strike that. 1 wall, the abdominal cavity is, therefore, 1 2 2 You would agree that the exposed to these same vaginal bacteria; abdomen and the peritoneal cavity would be 3 3 correct? exposed to these same bacteria from the 4 4 A. No. The suture is exposed, the 5 vagina if a hysterectomy is done at the time 5 part that's inside the vagina. I wouldn't 6 of a sacrocolpopexy; correct? 6 say the abdomen is exposed. 7 A. Then you have the ability to wash 7 O. Is it your belief that when the 8 8 suture is withdrawn or passed through, the it out. 9 Q. Let's just answer my question 9 bacteria cannot get through that same space? 10 first and then we can get into washing. 10 It could. How large are bacteria? 11 A. Yes. 11 Q. 12 When a hysterectomy is done at 12 Α. Tiny. the time of an abdominal sacrocolpopexy, the 13 13 Q. One, two microns. bacteria from the vagina can get into the I don't know. They're tiny. 14 14 A. 15 peritoneal cavity; correct? 15 They're smaller than the gauge of Q. Yes. the needle that you use when you suture; 16 A. 16 17 O. Any time there is a fresh 17 correct? 18 incision to the cuff where the uterus was at 18 A. I don't know. Well, I don't know the time of an abdominal sacrocolpopexy, how big the gauge -- I understand they are 19 19 20 those vaginal organisms can get into the 20 very, very small. abdominal cavity; correct? Q. Now, you mentioned you can wash 21 21 the abdomen out if you do a hysterectomy at 22 Α. 22 If you are doing an abdominal the time of a sacrocolpopexy; is that 23 23 sacrocolpopexy and a suture is passed 24 24 correct? 25 through the full thickness of the vaginal 25 A. Yeah. I don't do hysterectomies

Page 317 Page 318 so I'm going to be theorizing on what other Penile prostheses infections by 1 1 2 people's works are. Remember, if a woman 2 Dr. John Mulcahy at the University of 3 3 needs a hysterectomy, that goes to my Indiana. 4 4 gynecology colleagues. Infected penile prosthetics, a 5 5 prosthetic, if it comes infected, there's a Okay. Q. 6 6 protocol for washing it out. You can Α. But what I mean by washing it out 7 is in my OR specifically there is standard 7 actually wash out the bacteria under high 8 8 practice of constantly washing out any pressure and put a penile prosthesis in and 9 wound. The solution to pollution is 9 then the prosthesis has a high chance of 10 dilution. Okay. So we will use several 10 survival. So that is in a worst-case liters of antibiotic solution multiple times scenario. 11 11 12 throughout the case and at times actually 12 Q. But this clean contaminated 13 use Betadine. 13 vagina area has different bacteria than this 14 And what scientific literature or 14 penile prosthesis procedure; correct? data are you aware of that shows that if you The only one that would probably 15 15 do that, what you just said, in a case where be potentially different would be the 16 16 there's a concomitant hysterectomy done that 17 17 Candida. 18 the bacteria from the vagina would come --18 Q. Do you know the difference in the amount of bacteria released from performing be rendered either impotent or are 19 19 20 physically removed out of the entire 20 a hysterectomy when the uterus is cut out abdomen? and removed as compared to the amount of 21 21 bacterium released when there is this penile 22 A. I rely on data outside the 22 23 hysterectomy group for that, for that 23 prosthesis? 24 24 conclusion. Α. No. 25 25 Q. What data is this? Q. So is it correct, Doctor, that Page 319 Page 320 1 CERTIFICATE you are essentially extrapolating some data 1 2 2 from penile prostheses into the 3 I HEREBY CERTIFY that the witness was 4 3 sacrocolpopexy with concomitant hysterectomy duly sworn by me and that the deposition is a true 4 situation? 5 record of the testimony given by the witness. 5 I'm extrapolating infection data. 6 It was not requested before 6 MR. SNELL: What time is it, 7 completion of the deposition that the witness, 7 DANIEL STEVEN ELLIOTT, M.D., have the opportunity gentlemen? to read and sign the deposition transcript. 8 MR. ANDERSON: 7:00. 10 9 MR. SNELL: Let's shut down. (Whereupon the deposition 10 11 ROSEMARY LOCKLEAR adjourned at 6:56 p.m.) 11 12 REGISTERED PROFESSIONAL REPORTER 12 **TESTIMONY ADJOURNED** CERTIFIED COURT REPORTER (NJ) 13 30XT00171000 13 CERTIFIED REALTIME REPORTER 14 NOTARY PUBLIC 14 Dated: 12/10/12 15 15 16 16 17 17 (The foregoing certification of 18 18 this transcript does not apply to any 19 19 20 reproduction of the same by any means, 20 21 unless under the direct control and/or 22 supervision of the certifying reporter.) 23 22 24 23 24 25

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